Commonwealth of Massachusetts

Commonwealth of Massachusetts
Group Insurance Commission

FCHP Select Care

Member Handbook

Effective July 1, 2008

fallon community health plan

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009 the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

interpreter services

If you need an interpreter to understand our procedures when doing business with the health plan, we will make the arrangements for interpreter or translation services.

إذا كنت بحاجة إلى مترجم فوري لفهم إجراءاتنا عند التعامل مع الخطة الصحية، فسنتخذ الترتيبات اللازمة لنؤمّن لك مترجما فوريا أو خدمات ترجمة.

បើអ្នកត្រូវការអ្នកបកប្រែដើម្បីឲ្យយល់ពីដំណើរការរបស់យើងនៅពេលធ្វើការងារទាក់ទងជាមួយគំរោងសុខភាព យើងនឹងរៀបចំអ្នកបកប្រែឬកិច្ចបំរើទាងការបកប្រែ ។

Si ou bezwen entèprèt pou ou kapab konprann ki sa pou ou fè lè wap regle nenpòt bagay avèk plan de sante a, nap fè aranjman pou ou jwenn entèprèt oswa sèvis tradiksyon.

ຕ້ອງການນາຍພາສາ ເພື່ອທີ່ຈະເຂົ້າໃຈການດຳເນີນ ວຽກງານທັງຫຼາຍຂອງພວກເຮົາ ເວລາຕິດຕໍ່ວຽກງານ ກັບແຜນປິ່ນປົວສຸຂະພາບ. ພວກເຮົາຈະຈັດຫາບໍລິການແປພາສາໃຫ້ ແບບປາກເປົ່າຫຼືແບບຂຽນ.

Если Вам нужен переводчик, чтобы понять нашу политику, когда Вы имеете дело с планом медицинских услуг, то мы предоставим устного переводчика или услуги письменного перевода.

Si necesita un intérprete para comprender nuestros procedimientos al negociar su plan de salud, solicitaremos los servicios de un intérprete o traductor.

Quando estiver tratando do plano de saúde e por acaso necessitar de um intérprete para melhor entender os nossos procedimentos, nós podemos planejar os serviços de interpretação ou de tradução necessários.

If you need an interpreter to understand our procedures when doing business with the health plan, we will make the arrangements for interpreter or translation services.

Qualora aveste bisogno di un interprete per meglio comprendere le nostre direttive e le indicazioni del piano preventivo, saremo lieti di assistervi con servizi di interpretariato e traduzione.

Αν χρειάζεστε τις υπηρεσίες διερμηνέα για να καταλάβετε τις διαδικασίες μας όταν εργάζεστε με το πλάνο υγείας, θα κανονίσουμε ώστε να υπάρχουν διαθέσιμες υπηρεσίες διερμηνέα ή μεταφραστή.

Si vous avez besoin d'un interprète pour comprendre nos procédures dans le cadre du plan médical, nous prendrons les dispositions nécessaires pour obtenir les services d'un interprète ou d'un traducteur.

當您與本健保計劃接洽生意時，如果您須要口譯員協助您了解我們的程序，我們會安排口譯或翻譯服務。

Jeśli będzie Pan(i) potrzebował(a) tłumacza, ażeby zorientować się w naszym postępowaniu przy kontaktach z przedstawicielami planu ubezpieczenia medycznego, my załatwimy tłumaczenie lub przekład.

Nếu quí vị cần người thông dịch để hiểu rõ các thể thức của chúng tôi khi liên hệ thương mại về hợp đồng y tế, chúng tôi sẽ sắp xếp để có các dịch vụ thông dịch hay phiên dịch.

welcome!

Thank you for choosing Fallon Community Health Plan, Inc. (FCHP) for your health care coverage.

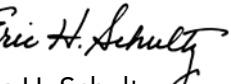
You've joined one of the top health plans in America, as rated by the National Committee for Quality Assurance (NCQA). FCHP also continues to receive "Excellent" accreditation status for both our commercial and Medicare plans.

Most importantly, FCHP is here for you every day. That's why we offer *Every Day Health*, a program that gives you the tools and resources you need to embrace a healthy lifestyle—and provides you with extra support when you need it.

This *Member Handbook/Evidence of Coverage* describes the benefits and other terms of coverage for persons enrolled in FCHP Select Care through the Group Insurance Commission. Those who may join FCHP include eligible employees of the Commonwealth of Massachusetts, Elderly Governmental Retirees (EGRs), Retired Municipal Teachers (RMTs), those employees and retirees of municipalities that have joined the GIC, and retirees not eligible for Medicare.

If you have any questions regarding this *Member Handbook/Evidence of Coverage*, please call FCHP Customer Service at 1-866-344-4GIC (TDD/TTY: 1-877-608-7677).

Once again, thank you for choosing Fallon Community Health Plan. We look forward to serving you.



Eric H. Schultz
President and CEO
Fallon Community Health Plan, Inc.

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this section contains:

glossary

Anniversary date: The date each year when most major changes to your health plan take effect. Group health plans usually allow subscribers to switch health plans during a designated "open enrollment" period prior to the anniversary date.

Authorization: An assurance by the plan to pay for medically necessary covered benefits provided by a network provider for an eligible plan member. In some instances, PCPs are given authority to issue an authorization for specialty care.

Calendar year: The 12-month period beginning on January 1 and ending on December 31.

Coinsurance: Your share of the allowed charge for certain covered benefits according to the fixed percentage specified in the "Your Cost for Covered Services" section under "Coinsurance."

Contract: The agreement that FCHP has with the Group Insurance Commission to provide benefits to you and your covered dependents.

Copayment: The fixed-dollar amount you are responsible to pay for certain covered services. The copayment amounts for services are listed in the addendum enclosed in this *Member Handbook*. Please note that most of your copayments are determined by a plan physician's tiering level.

Covered services: Health care services or supplies that are covered by the plan, as described in this *Member Handbook/Evidence of Coverage*.

Custodial care: A level of care which: (1) is chiefly designed to assist a person with the activities of daily life, and (2) cannot reasonably be expected to improve a medical condition. Custodial care is not covered by the plan.

Durable medical equipment: Medical care-related items that: 1) can withstand repeated use (e.g., could normally be rented), 2) are used in a private residence (not a hospital or skilled nursing facility), and 3) are primarily and customarily for a medical purpose and generally not useful to a person in the absence of illness or injury.

Effective date: The date, determined by the GIC, on which your coverage begins.

Emergency medical condition: A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in: (1) serious jeopardy to the health of the member or another person, or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency services: Inpatient and outpatient services, whether inside or outside the plan service area, that are: (1) furnished by a qualified provider and (2) needed to evaluate or stabilize an emergency medical condition.

Experimental/investigational: In cases where a drug, device, treatment or procedure does not meet one or more of FCHP's technology assessment criteria, the drug, device, treatment or procedure will be considered experimental or investigational. No coverage is provided

for drugs, devices, treatments or procedures that FCHP's Technology assessment committee considers experimental or investigational.

If the committee determines that a technology is experimental or investigational, FCHP will not pay for any services, including but not limited to, drugs, devices, treatments, procedures, or facility and professional charges related to that technology.

Fallon Clinic specialists: Specialists, including physicians, physician assistants, nurse midwives, and nurse practitioners, who are employed by the Fallon Clinic and who practice within the Fallon Clinic group practice.

Facility: A licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

FCHP: Fallon Community Health Plan, Inc. (also referred to as "the plan," "us," "we" and "our").

FCHP Select Care service area: The geographical area served by FCHP Select Care. The towns and cities in the FCHP Select Care service area are included in this *Member Handbook/Evidence of Coverage*.

Formulary: A list of prescription medications that are approved for coverage.

GIC: The Group Insurance Commission, the agency of the Commonwealth of Massachusetts which provides your group health plan. Also referred to as "plan sponsor."

Group: The GIC's program to provide health coverage, in which FCHP is a participating vendor.

Homebound: A member who has an injury/illness that restricts his or her ability to leave home without the aid of supportive devices or the assistance of another person, or if leaving home is medically contraindicated

Housekeeping services: Those routine and necessary tasks carried out within the home to maintain the functioning of the household. This may include routine housecleaning and related chores; laundry; food preparation and dish washing.

Inpatient: A registered bed patient in a licensed hospital or other facility.

Medical surgical supplies: Special products, such as materials used to repair a wound or instruments used for your care.

Medically necessary (service): A service or supply that is consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; (2) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) for services and interventions not in widespread use, is based on scientific evidence.

Member: Any person who has the right to services under this plan, which includes the subscriber and any family members covered under the subscriber's contract (also referred to as "you").

Network provider: A licensed physician or other healthcare professional, or hospital or other healthcare

facility, with whom we contract to provide covered benefits to plan members. This includes, but is not limited to, physicians, dentists, chiropractors, optometrists, podiatrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, and behavioral health professionals.

Network specialist: A licensed specialty physician or other specialty health care professional, with whom we contract to provide health care services to plan members. Specialists typically have a practice concentrated in a field of medicine in which a primary care physician may not have specialized training.

Nongroup membership: Your membership if you are not a member through a group. You pay your premium charge directly to FCHP.

Off-label: The prescribing of a medication in a different dose, for a different duration of time, or for a different medical indication than recommended in the prescribing information.

Open enrollment: A designated period, just prior to a group's anniversary date, when group members may change to another health plan or make changes to their existing health care contract. Any changes made become effective on the anniversary date.

Outpatient: A patient who is not a registered bed patient in a hospital or other medical facility.

Peace of Mind Program™: A medical management program (also referred to as "POM") which provides access to certain specialty care services at specified Boston medical centers, in specific circumstances described in this *Member Handbook/Evidence of Coverage*.

Plan: Fallon Community Health Plan, Inc. (also referred to as "us," "we," "our" and "FCHP").

Plan facility: Any inpatient hospital or other medical facility in the FCHP network, with which we contract to provide health care services to members.

Plan pharmacy: A licensed pharmacy in the FCHP network, with whom we contract to provide covered prescription drugs to members.

Plan physician: A licensed physician in the FCHP network, with whom we contract to provide health care services to members.

Plan provider: A licensed physician or other health care professional in the FCHP network, with whom we contract to provide health care services to members. This includes, but is not limited to: doctors of medicine, osteopathy and podiatry; registered nurse anesthetists; nurse practitioners; ambulance companies; and home health care providers.

Plan specialist: A licensed specialty physician or other specialty health care professional in the FCHP network, with whom we contract with to provide health care services to members. A specialist typically has a practice concentrated in a specific field of medicine in which a primary care provider may not have specialized training.

Plan sponsor: The Group Insurance Commission, the organization that provides your group plan.

Premium charge: The amount charged by FCHP for the coverage provided under this contract. (See how your coverage works for more information.)

Primary care provider (PCP): A network provider, specializing in internal medicine, family practice or

pediatrics, whom you choose to work with you to manage your medical care. Please note your copayments are determined by your PCP's tiering level. .

Provider: A physician or other health care professional or hospital or other health care facility licensed by the state to deliver or furnish health care services.

Referral: A recommendation by which a physician sends a member to another physician for services that are typically outside the referring doctor's scope of practice. Since plan physicians are freely able to recommend treatment options without restraint from the plan, a referral in and of itself does not guarantee that a recommended treatment is a covered benefit or that the accepting provider is contracted with the plan, and does not obligate the plan to pay for the service. Please note that referrals are not required for behavioral health services. See obtaining specialty care and services for a complete explanation of the referral and authorization process.

Room and board: Your room, meals and general nursing services while you are an inpatient.

Self-referral: The process by which you make an appointment directly with a plan provider without needing a referral from your PCP or an authorization from the plan. See obtaining specialty care and services for information on the services for which you can self refer.

Skilled home health care services: Services and/or equipment provided in the member's home, such as intermittent skilled nursing care, home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds,

oxygen, and walkers), medical supplies, and other services.

Subscriber: The person who is responsible for the premium charge. On this plan, this is typically a public employee or a retiree.

Technology Assessment Criteria: Fallon Community Health Plan (FCHP) maintains a formal mechanism for evaluating medical technologies through our Technology assessment committee. The committee includes physician administrators, practicing physicians from the plan's service area, and plan staff. When necessary, the committee seeks the input of specialists or professionals who have expertise in the proposed technology. In all cases, the technology is reviewed against the following technology assessment criteria:

1. The technology must have final approval from the appropriate government regulatory body. This applies to drugs, devices, biologics, and treatments or procedures that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the technology. Devices must have final FDA approval for the specific indications under evaluation by FCHP.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the study as well as the results is considered in evaluating the evidence. Opinions by national medical associations, consensus panels, or other technology evaluation bodies are evaluated

according to the scientific quality of the supporting evidence.

3. The evidence must show that the technology improves health outcomes. Specifically, the technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The technology must be at least as effective as the established technology. In addition, the technology must be as cost-effective as any established alternatives that achieve a similar health outcome.
5. The outcome must be attainable outside investigational settings.

Terminal illness: An illness as a result of which a member has a life expectancy of less than six months.

Tiering level: The level of quality and cost-efficiency in which a plan physician is placed.

Urgent care: Medical care that is needed right away for minor emergencies, such as cuts that require stitches, a sprained ankle or abdominal pain.

about this *member handbook/evidence of coverage*

This *Member Handbook/Evidence of Coverage* is effective July 1, 2008. There are no waiting periods or pre-existing condition limitations under this contract. You may use the services described here beginning on July 1, 2008, or on your effective date, whichever comes later.

This *Member Handbook/Evidence of Coverage* details the benefits and services that FCHP covers for persons enrolled through the Group Insurance Commission, explains our policies and procedures and contains other information such as:

- Definitions of important terms (underlined words are defined in our **glossary**)
- Important points to remember about FCHP
- Our customer service capabilities
- The FCHP service area
- The role of your primary care provider (PCP)
- Referral and authorization procedures
- Your rights and responsibilities
- Types of coverage available
- Claims procedures
- Additional contract provisions
- Covered services
- Your plan benefits

When you joined FCHP, you chose FCHP Select Care. You must use the providers in the FCHP Select Care network.

If we need to update or change this *Member Handbook/Evidence of Coverage*, we will send you an amendment.

If you have any questions regarding this *Member Handbook/Evidence of Coverage*, please call FCHP Customer Service at 1-866-344-4GIC (TDD/TTY: 1-877-608-7677).

understanding your health care coverage

Fallon Community Health Plan (FCHP) is a health maintenance organization (HMO) that provides health care coverage for its members through a network of health care professionals and hospitals. FCHP is incorporated under the laws of the Commonwealth of Massachusetts as a nonprofit organization, and qualifies under federal law as a health maintenance organization. Our administrative offices are located at Chestnut Place, 10 Chestnut St., Worcester, MA 01608.

As an HMO, FCHP requires you to use specific physicians, hospitals and other providers that are part of your plan. Understanding how your health plan works is important. For one thing, it helps you know what to expect. The following information highlights the most important points about how we work to ensure that you receive quality care and services.

- The FCHP Select Care provider network includes providers in Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Suffolk, Plymouth and Worcester Counties. In order for you to receive coverage for most services, care must be coordinated by your primary care provider (PCP) and administered by a provider in the FCHP network.
- When you join FCHP, you choose a primary care provider (PCP) who coordinates your health care.

Tier 1, 2 and 3 measurements of plan physician cost-efficiency and quality

Fallon Community Health Plan is committed to giving all our members access to a network of high-quality, cost-efficient plan physicians. The tiering works are as follows:

Tier 1 * (Excellent):** Plan physicians practicing at an excellent level of cost-efficiency and quality. You will pay the lowest copayment when you see a Tier 1 plan physician.

Tier 2 ** (Good): Plan physicians practicing at a good level of cost-efficiency and quality. You will pay the base copayment when you see a Tier 2 physician.

Tier 3 * (Standard): Plan physicians practicing at a standard level of cost-efficiency and quality. You will pay a higher copayment when you see a Tier 3 plan physician.

Note: Copayments to visit plan providers in specialties that are not tiered, for example: mental health and substance abuse providers, chiropractors and optometrists, will be at the Tier 2 base copayment amount of $15.

Not Tiered/Insufficient Data: Plan physicians for whom there is insufficient data with which to rate them and/or providers that belong to a specialty or subspecialty that is not being tiered by the health plan. You will pay the base copayment when you see a Tier 2 plan physician.

- You may change your PCP at any time.
- A referral is not required to see a Fallon Clinic specialist if you have a Fallon Clinic PCP.

- For other covered services, you should obtain a referral from your PCP, and in some cases, your physician will obtain authorization from the health plan.
- FCHP maintains a formulary, or a list of medications, approved for coverage.

your membership card

When you enrolled in FCHP, we mailed a membership card for each covered family member. Please carry the card with you at all times. Providers may ask you for your membership card when you seek medical care, or you may be asked for your card when you fill a prescription at a plan pharmacy.

You should receive your card within 30 days of the date that we receive and verify your enrollment request. If you do not receive a card, if the information on your card is incorrect, changes, or if you lose or damage your card, contact Customer Service to request a new card.

notifying us of changes

Call Customer Service and the Group Insurance Commission to report any changes in your name, address, phone number, primary care providers, number and status of dependents, or any other pertinent information. If there is a change to your family status that would require a change in contract type (for example, you have an individual contract, but you marry or have children), request a change in status through the Group Insurance Commission within 60 days of the event.

Whenever you change to a new primary care provider, we recommend that you have your medical records transferred to your new provider. Please note that Fallon Community Health Plan does not cover any cost associated with having your records copied.

questions? just ask.

Fallon Community Health Plan (FCHP) is committed to your satisfaction and helping you get the most from your plan membership. We offer many resources to help you, including a dedicated Customer Service and Member Relations staff. If you have questions, call:

Customer Service
1-866-344-4GIC
(TDD/TTY: 1-877-608-7677)

for answers to general questions or inquiries

Also see **inquiries, appeals and grievances.**

for help in choosing or changing your pcp

Also see **Choosing a primary care provider.**

with questions about your membership card

- If you do not receive a card
- If the information on your card is incorrect
- If you lose or damage your card

to notify the plan of changes

- To report any changes in your name, address, phone number, number of dependents, or any other pertinent information
- To change your contract type because of a change in your individual or family status

to order materials

- The *FCHP Select Care Provider Network* directory, which has a list of plan providers in the FCHP provider network
- Additional copies of this *Member Handbook/ Evidence of Coverage and any applicable riders, addenda or amendments*
- Weight Watchers® coupons

You'll find information and answers to many of your questions and be able to perform a number of transactions at our Web site.

our web site: www.fchp.org

For information on FCHP's products and services, log on and visit us at www.fchp.org. Our Web site offers you a place to learn more about FCHP, as well as a convenient and secure way of communicating with us. Among other things, you can use the site to:

- Search our regularly updated provider directory
- View the prescription drug formulary
- Request a new membership card
- Request plan literature
- Change your primary care physician
- Contact Customer Service

You can also learn more about our preventive health care guidelines read issues of *Healthy Communities*, our quarterly member health guide; and use our online health encyclopedia and reference guide for answers to your health questions. Can't find what you need online? Use our site search feature or contact the Webmaster with your suggestions.

this section contains:

choosing a primary care provider (pcp)

When you join Fallon Community Health Plan, you must choose a plan provider as your primary care provider (PCP). Your relationship with your PCP is very important, because he or she will work with us to provide or arrange most of your health care.

Your copayments for PCP visits are determined by the PCP's tiering level. You will pay the lowest copayment ($10) when you see at Tier 1 *** (excellent) PCP. You will pay the base copayment ($15) when you see a Tier 2 ** (good) PCP. You will pay a higher copayment ($25) when you see a Tier 3 *** (standard) PCP.

pcp choices

Each covered family member should choose his or her own PCP. This provider can be a:

- Family practice doctor (for members of all ages)
- Doctor of internal medicine (for members over 18)
- Pediatrician (for members under 18)

The *FCHP Select Care Provider Network* directory contains the names of plan providers who are available as PCPs, along with their address, admitting hospital(s) and tiering level. If you haven't selected a PCP and you don't have a provider list, Customer Service will send you a free directory, or provide you with further information on plan providers. You can also visit our Web site at www.fchp.org to obtain names of plan providers in your area.

You may change your PCP at any time by either calling Customer Service or completing the "Change provider" form on www.fchp.org.

Note: Please be aware that your PCP's tiering level will be re-evaluated on an annual basis. The re-evaluation may result in a change in your PCP's tiering level. You should check the annual provider directory or the GIC member portal at www.fchp.org for annual tiering level changes to PCPs.

make an appointment

Once you have selected a PCP, please notify Customer Service of your selection. It's also a good idea to schedule an initial appointment. This will allow your PCP to learn about you and your medical history and to begin assisting you with the coordination of any medical care that you may need. He or she can also help you with questions on

- Preventive care
- Prescriptions
- Specialty care
- Urgent care services
- Management of your ongoing medical needs

keep your PCP's phone number handy

It's also a good idea to keep your PCP's telephone number in your wallet and at home by your phone. If you need to see someone right away, your PCP (or an on-call provider) will direct you. Plan providers' telephones are answered 24 hours a day, seven days a week for emergencies and urgent care needs.

obtaining specialty care and services

When you have health care concerns, a good place to start is by contacting your PCP. Much of the time your PCP can provide the care that you need. Sometimes, however, you may need specialty care or services that your PCP does not provide.

If you and your PCP decide that a visit with a network specialist is medically necessary, your PCP will make the arrangements for you. For some services, your PCP is authorized to give you a referral to see a specialist. (See **pcp referral.**) For other services, your PCP must get authorization from the plan before giving you the referral. (See "Plan preauthorization" below.) If you receive services from any doctor, hospital or other health care provider without getting a referral from your PCP, you will have to pay for these services yourself (with the exception of those services listed under **self-referral** below).

When you joined FCHP, you chose FCHP Select Care. This means that you must use the health care professionals and facilities in the FCHP Select Care network. Remember, your copayments for physician specialist visits are determined by the specialist's tiering level. You will pay the lowest copayment ($15) when you see a Tier 1 *** (excellent) specialty physician. You will pay the base copayment ($25) when you see a Tier 2 ** (good) specialty physician. You will pay a higher copayment ($35) when you see a Tier 3 * (standard) specialty physician.

Note: Please be aware that specialty physician's tiering levels will be re-evaluated on an annual basis. The re-evaluation may result in a change in the specialty physician's tiering level. You should check the annual provider directory or the GIC member portal at www.fchp.org for annual tiering level changes to specialty physicians.

self-referral

In certain instances you can "self-refer" to an FCHP Select Care network specialist. This means that you can call the specialist and make the appointment yourself. You do not need a referral from your PCP but you must see an FCHP Select Care network provider.

Services you can self-refer for:

- Office visits with an FCHP Select Care network obstetrician, gynecologist, certified nurse-midwife or family practitioner, including annual preventive gynecological examination and any subsequent gynecological services determined to be necessary as a result of such examination; services for acute or emergent gynecological conditions; and maternity care. It does not include inpatient admissions or infertility treatment (unless provided by a Fallon Clinic specialist and you have a Fallon Clinic PCP).
- Office visits with a Fallon Clinic specialist (physician, physician assistant, nurse midwife or nurse practitioner only) *if you have a Fallon Clinic PCP.*
- Office visits to an FCHP Select Care network oral surgeon for extraction of impacted teeth. (Note: visits to an oral surgeon for any other procedure require authorization.)

- Routine eye examinations with an FCHP Select Care network ophthalmologist or optometrist.
- Outpatient mental health and substance abuse services with network providers. For assistance in finding a network provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

pcp referral

In some instances, your PCP can refer you to a specialist without authorization from the plan. Your PCP can provide you with a copy of the referral form and then you can make an appointment directly with the specialist for services. You do not have to do anything further and you will not get a letter from the plan.

Services that need a PCP referral, but do not need authorization from the plan:

- Office visits with an FCHP Select Care network specialist, with the exception of office visits with a Fallon Clinic specialist *if you have a Fallon Clinic PCP*. In some instances, your PCP may give you a "standing referral" to an FCHP Select Care network specialist for covered services. For a standing referral, your PCP and specialist must agree on a treatment plan, and the specialist must keep your PCP up to date on your treatment. Standing referrals are valid for up to 12 months, as long as the services are medically necessary.
- Podiatric care. Your PCP will give you a referral to an FCHP Select Care network podiatrist. The referral is good for a maximum of one year, or until the condition is corrected, whichever comes first.
- Chiropractic care. Your PCP will give you a referral to an FCHP Select Care network chiropractor for up to

five visits, if medically necessary. The chiropractor must obtain authorization from the plan for all subsequent visits.

- Physical, occupational and speech therapy. Your PCP will provide you with a written order to take to an FCHP Select Care physical, occupational or speech therapist. For physical and occupational therapy, the written order covers medically necessary services up to your benefit maximum. For speech therapy, the written order covers up to six visits if medically necessary. The speech therapist must obtain authorization from the plan for all subsequent visits.

plan preauthorization

For certain types of specialist visits and for certain specialty services, your PCP or specialist will need to obtain authorization from the plan **before** giving you a referral. An authorization is an assurance by the plan to pay for medically necessary covered services provided by an FCHP Select Care network provider to an eligible plan member.

When a service requires authorization, your PCP or specialist will send a request for services to the plan. We will review the request and make an authorization decision within two business days of receipt of all the necessary information. For the purposes of this section, "necessary information" may include the results of any face-to-face clinical evaluation or second opinion that may be required. We will inform your PCP of our decision within 24 hours of the time that we make the decision.

If we authorize the service, we will send you and your PCP an authorization letter within two business days thereafter. When you get the letter, you can call a plan specialist to make the appointment. If you do not get an authorization letter, you will be responsible for paying for the services.

The authorization letter will state the services the plan has approved for coverage. Make sure that you have this authorization letter before any services requiring authorization are furnished to you. If the specialist feels you need services beyond those authorized, the specialist will ask for authorization directly from the plan. If we approve the request for additional services, we will send both you and your PCP an authorization letter.

If we do not authorize a service, we will send you and your PCP a denial letter within one business day of the decision. The denial letter will explain our reasons for the decision and your right to file a grievance. For information on filing a grievance, see **inquiries, appeals and grievances**. Pending the outcome of the grievance process, in certain circumstances, such as for immediate or urgently needed services, the plan will provide for an automatic reversal of a denial of coverage for services or durable medical equipment, within 48 hours, or sooner for durable medical equipment, if your PCP tells us that in his or her opinion the provision of such service or durable medical equipment should not await the outcome of the normal grievance process and that the service or durable medical equipment is medically necessary and that immediate and severe harm will result if you do not receive the service within 48 hours or sooner for durable medical equipment. The plan will provide the coverage until we notify you of the outcome of your grievance.

Please refer to **expedited review** for additional circumstances for which you are entitled to request an expedited grievance.

Services requiring authorization from the plan include:

- Nonemergent admissions to a hospital or other inpatient facility
- Some same-day surgery (outpatient) and ambulatory procedures
- Services with a non-FCHP Select Care network provider
- Organ transplant evaluation and procedures
- Reconstructive surgery
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of the extraction of impacted teeth)
- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Home health care and hospice care
- Nonemergency ambulance
- Oxygen

Please note:

If a physician or other health care provider discusses a treatment option with you, this does not necessarily make that treatment a covered service. Physicians and other health care providers are freely able to discuss treatment options without restraint from the plan. However, services or supplies that are not described as covered in the **description of benefits** section of this *Member Handbook/Evidence of Coverage* and that do not receive any necessary authorization from the plan are not covered services. Services that are not medically necessary are not

covered services. Services and supplies you receive from providers who are not network providers are not covered services, unless you received authorization from the plan to go to that provider.

peace of mind program™

FCHP's *Peace of Mind Program* provides access to specialty services at specified Boston area medical centers. You may access *Peace of Mind Program* providers at your request if you meet the following conditions:

- The specialty service is ordinarily available in the FCHP Select Care network
- Care is for covered services as described in this *Member Handbook/Evidence of Coverage*. The same copayments and benefit limits apply.
- You have seen a plan specialist for this same condition within the past three months.
- A referral to a specific *Peace of Mind Program* physician is made by your PCP and notification of the referral is given to the plan.
- The provider to whom you are referred is on staff at one of the five medical centers listed below:
  - — Massachusetts General Hospital
  - — Brigham and Women's Hospital
  - — Children's Hospital (Boston)
  - — Dana-Farber Cancer Institute
  - — New England Medical Center
- If you receive any hospital-based services such as surgery, lab or X-rays, these services must be performed at one of the above hospitals or at another FCHP Select Care network hospital. If you see a specialist through the *Peace of Mind Program*, and the specialist recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the physician has obtained authorization from the plan. You must have a copy of the written authorization from the plan; do not

rely on assurances by the physician regarding plan coverage.

Once the plan has been notified of the *Peace of Mind Program* referral to a *Peace of Mind Program* specialist, you may see this specialist for a period of one year or until treatment for the presenting condition is complete, whichever comes first. When your course of treatment is complete, or for care for any non-related condition, you should return to your PCP for care.

If your *Peace of Mind Program* specialist wants you to see another specialist at the same facility for the same condition, your PCP must submit a separate referral to the plan before you see the other specialist.

If you want to see a *Peace of Mind Program* specialist for a different condition, the request must meet *Peace of Mind Program* conditions described above for the second condition, your PCP must submit a referral to the plan and you must receive prior authorization from the plan in order for the services related to the second condition to be covered.

Please note: For the period of time that you are authorized treatment with the *Peace of Mind Program* provider for a particular condition, the *Peace of Mind Program* provider may order X-rays, laboratory tests and other tests to evaluate that condition without prior authorization if these services would normally be covered and would require no prior authorization when ordered by a plan provider. All inpatient care or inpatient, outpatient, or office-based surgery requires prior authorization from the plan. For a complete list of services requiring prior authorization, see **obtaining specialty care and services**. Note that all PET scans and genetic testing require prior authorization.

If you need physical therapy or occupational therapy for the same condition for which your *Peace of Mind Program* specialist is treating you, your *Peace of Mind Program* specialist may refer you for such physical therapy or occupational therapy without prior authorization at the *Peace of Mind Program* facility, or you may return to a plan therapist if you want.

You may use the *Peace of Mind Program* for all specialty care except mental health, substance abuse, dental care, chiropractic services, obstetrics, speech therapy and infertility services. **You may not use the *Peace of Mind Program* for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, or if you or your physician have not obtained plan authorization for a *Peace of Mind Program* service, the services will not be covered by the plan and the *Peace of Mind Program provider* may hold you financially responsible.**

this section contains:

medical management

utilization management

FCHP's utilization and case management program reviews and evaluates the health care members receive to make sure that members' care is coordinated, and that appropriate levels of service are available to all members who require case management services.

The program is staffed by licensed registered nurse case managers, physician reviewers and specialists who are in routine contact with our health care providers. They use national, evidence-based criteria that are reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by your physician. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

FCHP also develops in-house criteria, making use of local specialist input and current medical literature, as well as guidelines from Medicare and the Commonwealth of Massachusetts.

To obtain information about the status or outcome of a utilization review decision, call FCHP at 1-866-344-4GIC, extension 69915 (TDD/TTY: 1-877-608-7677).

The plan does not provide compensation or other financial incentive or reward to its in-plan providers or staff who conduct utilization management review that is based on the quantity or type of denial decisions rendered.

quality management

FCHP's Quality Services Program systematically measures, monitors, evaluates and improves the performance of the managed care organization with respect to clinical care and service received by its members. Components of the program include careful attention to credentialing and recredentialing of providers, evaluation of all member complaints related to quality of care, and a formal peer review program to identify opportunities for improved care (on both an individual-practitioner level and a system-wide level). The plan also conducts focused performance projects related to plan-specific opportunities and formal chronic disease management programs appropriate to the plan's membership. With respect to service quality, the plan monitors and assures appropriate access to its contracted practitioners as well as complaints related to quality of service. A team of physicians, licensed registered nurses, and specialists create and regularly update clinical guidelines that are then shared with our contracted practitioners to promote preferred medical practices and to improve the quality of care. These guidelines are designed to complement rather than replace your doctor's clinical judgment.

assessing new technologies

FCHP maintains a formal mechanism for evaluation of new medical and behavioral health technologies, the new application of existing technologies, and the review of special cases, through our Technology Assessment Committee. The committee includes physician administrators, practicing physicians from the plan's service area, and plan staff who perform extensive literature review regarding the proposed technology, including review of information from governmental agencies, such as the U.S. Food and Drug Administration

(FDA), and published scientific evidence. We make use of external research organizations, which perform reviews of all available literature regarding a given procedure. When necessary, the committee seeks input from specialists or professionals who have expertise in the proposed technology.

The committee recommends for health plan coverage and develops written technology assessment criteria in accordance with standards developed by the National Committee for Quality Assurance (NCQA) for those technologies that can offer improved outcomes to our members without substantially increasing the risks of treatment. Criteria are reviewed at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted practice.

FCHP has a separate but similar process for evaluation of new drugs and medications, with reviews performed by our Pharmacy & Therapeutics Committee.

this section contains:

member rights and responsibilities

member rights

As a Fallon Community Health Plan member, you have the right to …

- Be informed about Fallon Community Health Plan and covered services.
- Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Community Health Plan, including payment structure.
- Choose a qualified contracted primary care physician and contracted hospital.
- Know the names and qualifications of physicians and health care professionals involved in your medical treatment.
- Receive information about an illness or condition, the course of treatment and prospects for recovery in terms that you can understand.
- Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.
- Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.
- Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider

in a manner appropriate to your condition and your ability to understand.

- Be treated with dignity and respect, and to have your privacy recognized.
- Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information (there may be a fee for photocopies).
- Make complaints and appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.
- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Community Health Plan and its contracted providers.
- Make recommendations regarding Fallon Community Health Plan's members' rights and responsibilities policies.

member responsibilities

As a Fallon Community Health Plan member, you have the responsibility to …

- Provide, to the extent possible, information that Fallon Community Health Plan, your physician or other care providers need in order to care for you.

- Do your part to improve your own health condition by following any treatment plan, instructions and care that you have agreed on with your physician(s).

- Understand your health problems, and participate in mutually agreed-upon treatment goals to the degree possible.

for answers to questions

About your rights or responsibilities as a member of Fallon Community Health Plan:
Fallon Community Health Plan, Inc.
10 Chestnut St., Worcester, MA 01608
1-866-344-4GIC
TDD/TTY: 1-877-608-7677

About care provided by a plan physician or for physician profiling information:
Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Ave., Suite G4, Boston, MA 02111
1-617-654-9800

notice of Group Insurance Commission privacy practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Group Insurance Commission (GIC) must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the GIC. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on the GIC's website at www.mass.gov/gic.

required and permitted uses and disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

payment activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

health care operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

other permitted uses and disclosures: *The GIC may use and share PHI as follows:*

- to resolve complaints or inquiries made on your behalf (such as appeals);
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements;

- to tell you about new or changed benefits and services or health care choices.

required disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

In connection with payment and health care operations, the GIC may share your PHI with third party "Business Associates" that perform activities on the GIC's behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give FCHP written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information which was used or shared based on your permission.

your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. *You must ask for this in writing*. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. *You must ask for this in writing, along with a reason for your request.* If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. *You must ask for this in writing*. The list will *not* include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. *You must ask for this in writing*. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.

- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. *You must tell us in writing that you are in danger, and where to send communications.*
- Receive a separate paper copy of this notice upon request. (an electronic version of this notice is on the GIC's website at www.mass.gov/gic.

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310 or TTY for the deaf and hard of hearing at (617)-227-8583.

July 1 2008

confidentiality

Maintaining the confidentiality of our members' personal health data is of the utmost importance to us. At Fallon Community Health Plan, we have developed policies and procedures protecting you from unauthorized individuals gaining access to or altering your medical records. We follow strict guidelines to ensure the privacy and confidentiality of your PHI (protected health information, such as your name or medical information). These guidelines require that your PHI be used only for purposes of treatment, payment and health plan operations, and not for purposes unrelated to health care.

We also ensure that our contracted providers extend the same protections to all personal health information under their control.

FCHP's *Notice of Privacy Practices* details how we use and share your information. This notice is provided to all members and is available on the FCHP Web site, www.fchp.org, or from Customer Service at 1-866-344-4GIC (TDD/TTY: 1-877-608-7677).

The *Notice of Privacy Practices* also provide information regarding your rights to access your own records, grant others access to your records and restrict access to your records by others. FCHP has developed forms to assist us in providing you with the level of access you require. These forms are available at www.fchp.org. Customer Service also will mail you a copy of any of the following forms upon request:

- **access request for personal information form**: To request a copy of certain personal information.
- **amendment request for personal information form**: To request changes to your record if you think it is inaccurate or incomplete. This form is not required for corrections to your address, date of birth or name.
- **authorization for release of personal information form**: To allow another individual/entity to receive your personal information from FCHP (such as your employer, if they are working on your behalf to resolve a claim issue).
- **personal representative authorization form**: To identify a personal representative—someone FCHP can release your personal information to. Complete a form for each person you want to have as a representative.
- **request for an accounting of disclosures of personal information form**: To request a listing of who FCHP has shared your information with (since April 14, 2003) for reasons other than treatment, payment or health care operations.
- **restriction form**: To request a limit on how we use or share your personal information.

inquiries, appeals and grievances

Whenever you have a question or need help using plan providers and services, FCHP encourages you to contact Customer Service. If you have a question or concern regarding an adverse determination or if you would like to file an appeal or grievance, contact Member Relations.

An adverse determination means that FCHP has made a decision, based on the review of information provided to us, that denies, reduces, modifies or terminates coverage for health care services because the treatment does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

making an inquiry

If you have a question or need help with an issue that is not about an adverse determination, contact Customer Service. You can reach our Customer Service Representatives in the following ways:

Call: 1-800-868-5200 (TDD/TTY: 1-877-608-7677)
Monday through Friday, 8 a.m. to 6 p.m.
E-mail: contactcustomerservice@fchp.org
Write: Fallon Community Health Plan
Customer Service Department
10 Chestnut St.
Worcester, MA 01608

In most cases, our Customer Service Representatives will be able to answer your question or handle your request the first time you call. In some cases, however, FCHP may need to do more research before FCHP completes your request. In these cases, FCHP will make every effort to provide you with a response within three business days. If

FCHP has not been able to provide a satisfactory response to your inquiry within this time period, FCHP will send you a letter explaining your right to continue with the inquiry process or to have your request handled as a grievance. If you tell FCHP that you want to have your issue handled as a grievance, FCHP will proceed to the grievance procedure outlined below.

filing an appeal: internal appeal review

If you disagree with an adverse determination about coverage related to your care, you may file an appeal. An appeal is a request to change a previous decision made by FCHP.

You may file the appeal yourself, or with the completion of the appropriate authorization form, you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your appeal within 180 calendar days from when you received the written denial. FCHP can extend this 180-day limit if you have a good reason. If you do, state the reason when you file your grievance.

If you file an appeal, be sure to give us all of the following information:

- The member's name
- The FCHP identification number
- The facts of the request
- The outcome that you are seeking
- The name of any representative with whom you have spoken

You can file an appeal in any of the following ways:

Write:	Fallon Community Health Plan, Inc. Member Relations Department 10 Chestnut St. Worcester, MA 01608
Call:	1-800-333-2535, ext. 69950 (TDD/TTY: 1-877-608-7677) Monday through Friday 8:30 a.m. to 5:00 p.m.
E-mail:	grievance@fchp.org
Fax:	1-508-755-7393
In person:	Fallon Community Health Plan, Inc. Member Relations Department 10 Chestnut St. Worcester, MA 01608

If you send us a written or electronic appeal, we will acknowledge your request in writing within 15 business days from the date we receive the request, unless you and the plan both agree in writing to waive or extend this time period. We will put an oral appeal made by you or your authorized representative in writing and send the written statement to you or your authorized representative within 48 hours of the time that we talked to you, unless you and the plan both agree in writing to waive or extend this time period.

We will complete our review and send you a written response within 30 calendar days from the date that we receive your request. If the appeal followed from an unresolved inquiry, the 30-day period will start three business days from the date FCHP received the inquiry or on the day you advise us that you are not satisfied with the results of your inquiry, whichever

comes first. These time limits may be waived or extended if you and the plan both agree in writing to the change. This agreement must note the length of the extension, which can be up to 30 days from the date of the agreement.

In some cases, FCHP will need medical records to complete our review of your appeal. If we do, we will ask you to sign a form to authorize your provider to release the records to us. If you do not send this form within 30 calendar days, FCHP will complete the review based on the information that we do have, without the medical records.

Your appeal will be reviewed by individuals who are knowledgeable about the matters at issue in the appeal. If your appeal is about an adverse determination, the reviewer will be an individual who did not participate in any of the plan's prior decisions on the issue. The reviewer will be a health care professional who is actively practicing in the same or similar specialty that is the subject of your appeal.

Our response will describe the specific information we considered as well as an explanation for the decision. If the appeal is about an adverse determination, the written response will include the clinical justification for the decision, consistent with generally accepted principles of professional medical practice; the information on which the decision was based; pertinent information on your condition; alternative treatment options as appropriate; clinical guidelines or criteria used to make the decision; and your right to request external review and the process for doing so.

opportunity for reconsideration

If relevant information was received too late, or is expected to become available within a reasonable time period, for internal review, you may ask for a reconsideration of a final adverse determination. In this case, FCHP would agree in writing to a new time period for review. This would not be longer than 30 days from the date FCHP agrees to the reconsideration.

expedited review

You can request an expedited (fast) review either orally or in writing concerning coverage for immediate and urgently needed services.

1. *Inpatient admission:* During your inpatient admission and prior to discharge, a written decision will be provided to you. If the expedited review results in a denial of coverage regarding the continuation of inpatient care, you will have the opportunity to request an expedited external review and the opportunity to request continuation of services through the external review process available through the Office of Patient Protection (OPP).

2. *Immediate and Urgent services:* You will receive a written determination within 48 hours, if your treating physician certifies that the treatment or proposed treatment is:
    a. Medically necessary;
    b. A denial of coverage for the services would create a substantial risk of serious harm to you; and

c. Such risk of serious harm is so immediate that the services should not await the outcome of the standard grievance process.

If the expedited review process results in an adverse determination, you will be informed of the opportunity to request an *expedited* external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

3. *Durable medical equipment:* You will receive a written determination within less than 48 hours, if your physician certifies that:
   a. Certifies that this equipment is medically necessary;
   b. Certifies that that the denial of the equipment would create a substantial risk of serious harm;
   c. Certifies that such risk of serious harm is so immediate that the services should not await the outcome of the standard grievance process;
   d. Describes the specific immediate and severe harm if no action is taken within the 48 hour time period; and
   e. Specifies a reasonable time period in which FCHP must respond.

If the expedited review process results in an adverse determination, you will be informed of the opportunity to request an *expedited* external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

In the specific instances noted above, you will receive a response within 48 hours.

expedited review for terminally ill members

If you are terminally ill, you can request an expedited review of your appeal. A determination will be provided to you within five business days from receipt of your appeal request, and will include the specific medical and scientific reasons for denying coverage or treatment, along with information on any covered alternative treatments, services or supplies.

If your request for coverage or treatment is denied, you may request and attend a conference at FCHP, for further review. The conference will be scheduled within 10 days of receiving your request unless your treating physician determines, after discussion with the FCHP Medical Director or designee, that an immediate conference is necessary. In that case, the conference will be held within five business days. You may participate at the conference in person or via telephone, however, your attendance is not required. If the conference results in a final adverse determination, you may request an expedited external review through the Office of Patient Protection. If your appeal involves the termination of ongoing coverage or treatment, this coverage or treatment will continue at the plan's expense until we complete our review, regardless of the final decision.

filing an appeal: external appeal review

An external appeal is a request for an independent review of the final decision made by FCHP through its internal appeal process. If your appeal involved an adverse determination, and you are not satisfied with our final decision, you have the right to file the case with an

external review agency. You must request this in writing within 45 days from receiving the written notice of the final adverse determination.
If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage or treatment. You must file this request by the end of the second business day after receiving the final adverse determination. If the external review agency finds that termination of services would cause you substantial harm, they may order continuation of coverage at our expense, regardless of the final external review determination.

expedited external review

You may request an expedited (fast) external review. In this case you must submit a written certification from your physician stating that a delay in providing or continuing the health care services that are the subject of a final adverse determination would pose a serious and immediate threat to your health.

You must file your request for external review or expedited external review with:

Department of Public Health
Office of Patient Protection
250 Washington St., Second floor
Boston, MA 02108

For more information about this process, or to file an external review, please contact OPP at 1-800-436-7757 (www.state.ma.us/dph/opp).

Your request should:

- Be on the form determined by the Office of Patient Protection
- Include your signature or your authorized representative's signature
- Include a copy of the written final adverse determination made by FCHP
- Include the $25 fee required. The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the member.

filing a grievance

A grievance is the type of complaint you make if you have any other type of problem with FCHP or one of our plan providers. You would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

If you have a grievance, our Member Relations coordinators are available to assist you in accordance with your rights and in confidence.

You can file a grievance in any of the following ways:

Write: Fallon Community Health Plan, Inc.
Member Relations Department
10 Chestnut St.
Worcester, MA 01608

Call: 1-800-333-2535, ext. 69950
(TDD/TTY: 1-877-608-7677)
Monday through Friday, 8:30 a.m. to 5:00 p.m.
E-mail: grievance@fchp.org
Fax: 1-508-755-7393
Walk-in: Fallon Community Health Plan, Inc.
Member Relations Department
10 Chestnut St.
Worcester, MA 01608

You may file the grievance yourself, or with the completion of the appropriate authorization form, you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your grievance within 180 calendar days. FCHP can extend this 180-day limit if you have a good reason. If you do, state the reason when you file your grievance.

If you file a grievance, be sure to provide all of the following information:

- Member name
- Member identification number
- Facts of the request
- Outcome that you are seeking
- Name of any representative with whom you have spoken

A Member Relations representative will acknowledge your oral grievance within 24 to 48 hours of receipt. Written grievances will be acknowledged within 15 calendar days of receipt. We will contact you within 30 calendar days of receiving your grievance to discuss a possible resolution of your concern.

failure to meet time limits

If we do not complete a review in the time limits specified above, the decision will automatically be in favor of the member. Time limits include any extensions made by mutual written agreement between you or your authorized representative and the plan.

massachusetts office of patient protection

The Office of Patient Protection (OPP) was established within the Massachusetts Department of Public Health with the authority to administer and enforce the standards and procedures established under Massachusetts state law. The OPP will make information on managed care plans accessible to consumers, assist consumers with questions and concerns related to managed care, monitor quality-related plan information relating to managed care practices and regulate the external review process. FCHP and other Massachusetts plans provide the following information to OPP by April 1st of each year:

- Member satisfaction rates and quality of care rates for the plan
- The number of physicians who voluntarily or involuntarily left the plan network last year
- The percentage of plan premium revenue that went towards health care compared to the amount that went towards plan administrative expenses
- The number of grievances filed in the last year by plan members, and the outcome of those grievances. This will include the total number of grievances filed, grievances that were approved internally, grievances withdrawn before resolution, and external reviews filed with OPP.

The Office of Patient Protection can be reached by phone at 1-800-436-7757; by fax at 1-617-624-5046; or via their Web site at www.mass.gov/dph/opp.

this section contains:

the claims process

claims, reimbursements and refunds

You should never receive a bill for any covered services from a plan provider. Your plan provider has an agreement with the plan to send claims directly to us. If you do receive a bill for covered services, write your FCHP coverage information on the back of the bill and return it to the provider's office with a request to bill us directly.

urgent/emergency room bills

If you receive a bill for urgent or emergency care from a non-plan provider, send it to us within one year of the date of service. You may submit the bill yourself, or the provider may submit it directly. All bills should include a description of the services, the diagnosis, the dates of services and the charge for each service.

Send bills to:

Fallon Community Health Plan, Inc.
Claims Department
P.O. Box 15121
Worcester, MA 01615-0121

We will make payment directly to the provider unless you prove that you have already paid the bill.

care in foreign countries

You may submit claims for urgent or emergency services in a foreign country if the services are not provided free of charge by that country. The bills must be itemized and in (or translated into) English. Payment will be made to you, and you must pay the provider.

recovering money owed

We have the right to recover any money you owe to us, a health plan physician, or a health plan facility, or any other person or facility providing services to you on behalf of the plan. We will do so by offsetting the amount you owe us with any reimbursement payments we may owe you. This will satisfy our obligation to pay for services you receive.

claims questions/refunds

If you have a question regarding a claim, you should contact Customer Service. If you feel you are entitled to an adjustment or refund due to discrepancies in the effective date of your coverage or your contract type, send a letter to:

Fallon Community Health Plan, Inc.
Customer Service Department
10 Chestnut St.
Worcester, MA 01608

We will not approve an adjustment or refund if it is for something that took place more than one year before we receive your letter, or if it is for an amount less than $5.

coordination of benefits

Coordination of benefits (COB) takes place when more than one health insurance plan covers a service. This includes plans that provide benefits for hospital, medical or other health care expenses.

Under COB, one plan pays full benefits as the primary carrier. The other (the secondary carrier) pays the balance of covered charges. The primary and secondary carriers are determined by the standard rules that are used by all insurance companies.

We have the right to exchange benefit information with any other group plan, insurer, organization or person to determine benefits payable using COB. We have the right to obtain reimbursement from you or another party for services provided to you. You must provide information and assistance and sign the necessary documents to help us receive payment. You must not do anything to limit this repayment. If payments have been made under any other plan that should have been made under this plan, we have the right to reimburse the plan to the extent necessary to satisfy the intent of COB. If we pay benefits in good faith to a plan, we will not have to pay such benefits again. We also have the right to recover any overpayment made because of coverage under another plan.

We will not duplicate payment for any service. We will not make payment for more than the full benefit available under this contract. If we provide or arrange services when another carrier is primary, we have the right to recover any overpayment from the primary carrier or other appropriate party. If we do not receive the necessary documentation from you, we may deny your claim.

In order to obtain all the benefits available, you must file claims under each plan.

subrogation

Subrogation (a process of substituting one creditor for another) applies if you have a legal right to payment from an individual or organization because the individual or organization was responsible for your illness or injury.

We may use your subrogation right, with or without your consent, to recover from the responsible party or that party's insurer the cost of services provided or expenses incurred by us that are related to your illness or injury. We will notify you of our right to reimbursement prior to settlement or judgment. If you are reimbursed by the responsible party, we have the right to recover from you the cost of services provided or expenses incurred. Our right to repayment comes first, even if you are not paid for all your claims against the other party, or if the payment you receive is described as payment for other than health care expenses. Any recovery from your personal injury protection coverage under a Massachusetts automobile policy shall be limited in accordance with the law. If we do not receive the necessary documentation from you, we may deny your claim.

workers' compensation

The plan does not cover any services or supplies that are covered by workers' compensation insurance or a similar program. If you are eligible for workers' compensation or a similar employer's liability coverage, we may request information from you before processing claims. If we do not receive the necessary documentation from you, we may deny your claim.

medicare

If you are entitled to Medicare, Medicare is generally considered to be your primary health insurance, even if you also have health coverage provided by the plan. However, there are some circumstances in which the plan might be primary over Medicare. Your age, work status and (if you are eligible for Medicare due to disability) the presence of specific disabling medical conditions may

affect which coverage is considered to be your primary insurance.

If you are entitled to Medicare, and Medicare is your primary carrier, we have a legal right to obtain reimbursement for services provided to you by us or a provider you see on a referral, if the services are covered by Medicare.

important notice about your prescription drug coverage and medicare

The Centers for Medicare Services requires that this *NOTICE OF CREDITABLE COVERAGE* be sent to you.
Please read it carefully and keep it where you can find it.

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. This notice

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and the new Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS', SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

the new medicare drug plans

The new Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All

Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans might also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon *Senior Plan*, you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

creditable coverage information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage will pay. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security

Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. After May 15, 2006, if your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.medicare.gov .
- Call the Group Insurance Commission at 1-617-727-2310.

Medicare part d final creditable coverage notice 05

this section contains:

how your coverage works

eligibility

You are eligible to enroll in the plan as a subscriber as long as you live in the FCHP Select Care service area and you meet the plan's underwriting guidelines.

In general, you may make changes to your insurance coverage only once a year during a designated "open enrollment" period prior to the anniversary date. Any changes that you make become effective on the anniversary date. If you have any questions about your group's enrollment period or anniversary date, please contact the GIC.

New subscribers may enroll in this plan during open enrollment, or within 31 days of the date they are first eligible. Employee eligibilty will begin on the first day of the month following 60 days of employment or two calendar months, whichever is less. New subscribers may also be eligible to enroll at a later date under the following circumstances:

- You declined this coverage when first eligible because you or your eligible dependent were covered under another group health plan or another health insurance coverage, but the other coverage has ended. You and your dependent may enroll in this plan within 31 days of your termination of coverage under the other health plan.
- You declined this coverage when first eligible, but have since acquired a dependent through marriage, birth or adoption. You or your dependent may enroll within 31 days of the date of the marriage, birth or adoption (including any probationary period).

Except for the above circumstances, employees who choose not to join the plan when first eligible must wait until the next open enrollment period to join.

premium charge

As a Fallon Community Health Plan subscriber, you are enrolled in a health plan that provides comprehensive benefits and quality care. In order to provide this plan for you, the Group Insurance Commission pays Fallon Community Health Plan a monthly premium charge. Your coverage may be terminated if the GIC fails to pay, even if they have charged you all or part of the premium charge (for example, by withholding it from your pay). For the plan year beginning July 1, 2008, and ending June 30, 2009, this amount will be:

$468.17 per month for individual coverage
$1,123.60 per month for family coverage

failure to pay premiums

If we or our agent do not receive the premium charge by the time it is due, your coverage will be suspended and your contract terminated as described in **cancellation by fchp**. There is a 15-day grace period, following which the contract will be suspended for nonpayment of the premium charge. Group contracts will be cancelled on the 30th day after the due date if the premium charge is not received. You will be covered through midnight on the last day for which payment was received.

types of coverage

The subscriber may choose between individual coverage and family coverage.

If a subscriber chooses individual coverage, the contract covers only the subscriber.

If a subscriber chooses family coverage, the contract may cover:

- The subscriber
- The subscriber's legal spouse
- Dependent children under 26 years of age or for two years after the end of the calendar year in which such children last qualified as dependents under 26 U.S.C. 106, whichever occurs first.
- Dependent children who, by age 19, are mentally or physically incapable of earning a living. These children, while dependents under the family contract, must get approval from the GIC to enroll or continue coverage under the family contract after the end of the month in which they turn 19.
- A former spouse, as long as the divorce decree allows for it, and neither the subscriber nor the former spouse has not remarried

"Dependent children" includes your or your spouse's children by birth or adoption; children who are under your or your spouse's legal guardianship; and children who are dependent upon you for support, live in your household, are under age 19, and have a parent-child relationship with you (these children must get approval from the GIC to enroll under the family contract). Adopted children are included from the date of placement in the home or, in the case of a foster child, from the date of the filing of the

petition to adopt. If your dependent child has a child, that child is included as a family member as long as your dependent child remains eligible. (See **age limits for dependent children**.)

adding dependents

The subscriber may always change to family coverage, or add additional dependents to family coverage.

In addition, the subscriber may change to family coverage or add dependents to family coverage at the time of the following qualifying events:

- The subscriber marries. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. If a former spouse has been covered prior to the subscriber's marriage, the former spouse may, if the divorce judgment so permits, continue coverage under an individual policy with a separate premium for that policy. Coverage ends if the former spouse remarries or moves out of the FCHP service area.
- Birth or adoption of a child. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. Coverage will be retroactive to the newborn's date of birth. (See **changing your coverage**.)
- Loss of other health insurance coverage by a spouse and/or child(ren) who are not currently covered under the subscriber's contract. The subscriber may add only those dependents who have lost their other coverage. If the previous coverage was not through FCHP, we will require notification from the prior insurance company.

- A spouse and/or child(ren) who formerly lived outside the FCHP Select Care service area move into the service area. The subscriber may add only those dependents who have just moved into the service area.
- A dependent child under age 26, who is not currently covered under the subscriber's contract, becomes an eligible dependent under IRS guidelines (or has been an eligible dependent within the last two years). The subscriber may add that person as a dependent on his or her plan.
- The GIC determines that a court order permits the subscriber to provide coverage for a spouse, former spouse or child(ren). See **divorce** for more information about coverage of former spouses in the event of divorce.

Hospital charges for the routine care of a newborn following delivery are covered under either individual or family coverage. Any other services for your newborn children or other new dependents are covered only if the dependent is enrolled under your family coverage.

For information on nongroup enrollment, see **changing to a consumer plan**.

changing your coverage

A change made at the time of a qualifying event will be effective on the date of the qualifying event if the premium is paid when due. You must notify the GIC of the change within 60 days of the event. If you do not request the change within the 60-day period, you may not make a change until your next anniversary date.

age limits for dependent children

A dependent child is eligible for coverage until his or her 26th birthday or for two years after the end of the calendar year in which such child last qualified as a dependent under 26 U.S.C. 106, whichever occurs first. Coverage under the family contract ends at the end of the month of his or her 26th birthday. Dependent children may be eligible to remain under the family coverage indefinitely if they are disabled; see the following sections for more information.

A dependent child who is no longer eligible due to age also may be eligible for continuation of coverage or conversion to a consumer plan. (See **conversion options** for more information.)

Whenever a dependent child's coverage under the family coverage ends, the coverage for any offspring of that dependent child also ends.

disabled dependents

A dependent child who is mentally or physically disabled when he or she reaches age 19, and is not capable of earning his or her own living, can remain on the family contract. The subscriber or the plan sponsor must apply within 30 days of the dependent child's 19th birthday.

The GIC determines eligibility for disabled children. The subscriber must supply the GIC with any medical or other information that may be needed to determine if the child is eligible to continue coverage.

student dependents

What happens when my child turns 19?
Coverage for a dependent who is turning 19 ends on the last day of the month in which the dependent turns 19 unless the dependent is eligible to continue coverage. The GIC will send you a *Dependent Age 19 or Over Application for Coverage* 60 days prior to your dependent's 19th birthday.

If your dependent is an IRS dependent he or she is eligible to continue coverage under your family health plan up to the age of 26 or for two years after the end of the calendar year in which such child last qualified as a dependent under 26 U.S.C. 106, whichever occurs first. To continue uninterrupted coverage you need to return the *Dependent Age 19 or Over Application for Coverage* within 30 days of the dependents 19th birthday. Applications received at the GIC more than 30 days after the dependents 19th birthday will have coverage beginning on the first day of the second month after receipt of the application.

Thereafter, once each year, a *Dependent Age 19 or Over Application* will be sent to your home address to verify your DEPENDENT student's status. The application for continued coverage must be completed and returned within the stated time. If the application is not returned coverage will end.

What happens when my full-time student dependent turns 26?
Full-time students aged 26 or over are eligible for coverage as a student dependent. Student dependent coverage is full-cost individual coverage, with no contribution from the Commonwealth. To cover your

dependent as a student dependent age 26 and over, you must complete a *Dependent Age 19 or Over Application for Coverage.* Student DEPENDENT coverage ends at the end of the month in which the student last attended class on a full-time basis or graduates whichever comes first. Full-time students aged 26 or over are not eligible for continued coverage if there has been a two-year break in coverage with the GIC after the student has reached age 26.

Please see pages 101 to 109 of this *Member Handbook* for an explanation of dependent continuation rights.

residency and student requirements

Dependent benefits vary based on the dependent's residency and his or her student status:

- Dependents who are full-time students and who are residents of Massachusetts:
  - Are covered for the services listed in **out-of-area student coverage** in the **description of benefits section** when attending school outside of the service area
  - Are covered for all services listed in the **description of benefits** while inside the service area
- Dependents who are no longer residents of Massachusetts:
  - Have no coverage under this plan. Claims will not be paid for any charges incurred by these dependents.

continuing coverage for former dependents

A dependent child who is no longer eligible for coverage may be eligible for continuation of coverage or conversion to a consumer plan. (See **conversion options** for more information.)

surviving dependents

In the case of the death of an employee or retiree, the surviving spouse may continue coverage until remarriage. The surviving spouse must apply to the GIC for this coverage within 60 days of the date of death.

In the case of death of a single or divorced employee or retiree, or a surviving spouse of a deceased employee or retiree, dependent children may continue coverage under this program until age 19 or until they become eligible for other group health coverage, whichever is earlier. Applications for continued coverage must be made within 60 days of the death of the insured parent.

divorce

In the event of divorce, the subscriber's former spouse may remain under the family coverage. Coverage may continue, with no additional premium due, unless: (1) the divorce decree specificially states that the subscriber is not required (or is no longer required) to maintain health insurance coverage for the former spouse, or (2) either the subscriber or the former spouse remarries.

If the subscriber remarries and wishes to add his or her new spouse to the family coverage, the former spouse remains eligible for the subscriber's coverage. However, the former spouse must move from family coverage to individual coverage and he or she will pay the full cost of the premium; the former spouse only remains eligible

under the group if the divorce decree provides for such coverage. If the former spouse remarries or moves out of the FCHP service area, the former spouse's eligibility ends.

Notice of cancellation of coverage of a former spouse will be mailed to the former spouse at his or her last known address, along with notice of any applicable right to reinstate coverage retroactively to the date of cancellation. The former spouse may be eligible for continuation of coverage or conversion to a consumer plan. (See **conversion options** for more information.)

this section contains:

fallon community health plan contract arrangements

changes in your coverage

We may change part of your coverage. If we do, the change will apply to all contracts of this type, not just your contract. We will send you notice of any material modifications to your coverage within 60 days of the change. The contract will be changed whether or not you receive the notice. The notice will indicate the effective date of the change.

When we send you a notice, we will mail it to the most recent address on file. This includes your bill for premium charges and any notices informing you about changes in the premium charge or changes in the contract. If your name and mailing address change, let us know so that our records can be updated. Be sure to give us your old name and address as well as the new information.

fchp contracting arrangements

The plan contracts with individual physicians, medical groups, hospitals and ancillary providers to provide care to members. FCHP negotiates with providers to agree upon a contracted payment rate. The providers then accept that payment for their services. When you obtain a covered service, the only payment that a provider will collect from you for a covered service is the copayment amount shown in this *Member Handbook/Evidence of Coverage*, or in any applicable riders or addenda.

FCHP pays its providers using various payment methods including fee for service, capitation and per diem. Fee for service means payments are based on an agreed upon fee schedule. Capitation means paying a fixed dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered.

when your provider no longer has a contract with us

We cannot guarantee that any one physician, hospital or other provider will be available and/or remain under contract with us. We reserve the right at any time to end our contract with your PCP or with any other plan provider who may be treating you. If this occurs, we will generally no longer pay for services provided to you by that provider, except in the circumstances listed below.

If the provider whose contract we are ending is your PCP, we will notify you in writing at least 30 days prior to the date of the end of his or her contract, except where the contract has been ended for reasons involving fraud, patient safety or quality of care. If your PCP ends his or her contract with us, we will notify you of the change either 30 days prior to the date the contract ends, or as soon as we are notified of the termination, whichever is sooner.

If our contract with your PCP ends, you will be required to select a new PCP. We will also notify you if you are receiving regular care from a specialist, and that specialist will no longer be under contract with us.

We will continue to pay for services of your provider after our contract with the provider ends, in the following circumstances only:

- If our contract with your PCP ends, you may continue to receive treatment from that provider for 30 days beyond the end of the contract, except in circumstances of gross misconduct.
- If you are in the second or third trimester of pregnancy when our contract with a provider from whom you are receiving pregnancy-related treatment ends, you may continue to receive treatment from that provider through your postpartum period.
- If you are terminally ill and our contract with a provider from whom you are receiving treatment related to that illness ends, you may continue to receive treatment from that provider.

In all cases, the provider must agree to accept reimbursement for services at the rates in effect when our contract with the provider ended, and to adhere to our quality assurance standards and other policies and procedures such as referrals and prior authorization. You will be eligible for benefits as if the provider had remained under contract with us.

If your provider is no longer under contract with us, call Customer Service for assistance in choosing a new PCP or to request a provider directory. You also can get provider information and choose a new PCP on our Web site at www.fchp.org.

continuation of services with a non-plan provider

Once you become a plan member, we will generally only pay for services that you receive from plan providers. However, there are some circumstances in which we will temporarily pay for services that you receive from a non-plan provider, if you had been receiving care from that provider prior to becoming a member:

- If your prior PCP is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider for 30 days from your effective date.
- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider for 30 days from your effective date.
- If you are in the second or third trimester of pregnancy, and you are receiving services related to your pregnancy from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider through your postpartum period.
- If you are terminally ill, and you are receiving ongoing treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for your services from that provider until your death.

In all cases, the provider must agree to accept reimbursement for services at our rates, and to adhere to our quality assurance standards and other policies and procedures such as obtaining appropriate referrals and prior authorizations. You will be eligible for benefits as if

the provider was under contract with us, and your copayments will be at the Tier 2 base copayment amount.

responsibility for the acts of providers

The arrangement between the plan, plan providers and the plan facilities is that of independent contractors. They are not our agents. We are not liable for injuries or damages resulting from acts or omissions by them or by any other institution or person providing services to you. You should not rely on providers or facilities for any assurances or interpretation of plan policies or benefits. We will not interfere with the ordinary relationship between providers and their patients except in circumstances in which a provider does not comply with health plan policies.

If you are admitted to a hospital or other facility as an inpatient, or if you are an outpatient, you will be subject to all of that facility's rules. This includes rules on admission, discharge and the availability of services.

If a provider recommends or provides a specific treatment, this does not necessarily make that treatment a covered benefit. Since plan providers are freely able to recommend treatment options without restraint from the health plan, a referral or recommendation in and of itself does not guarantee that a referral or recommended treatment is a covered benefit or that the accepting provider is contracted with the plan, and does not obligate the plan to pay for the service. Services or supplies that are not described as covered in this *Member Handbook/Evidence of Coverage*, or that did not receive any necessary authorization from the plan, are not covered benefits.

circumstances beyond our control

Under extraordinary circumstances that are beyond our control, we may have to delay your services, or we may be unable to provide them at all. We will not be liable for failing to provide, or for a delay in providing, services in the cases described below. We will, however, make a good faith effort to provide or arrange for services in these situations, limited by available facilities and personnel:

- In the case of major natural disasters or epidemics
- In the case of a war, riot or civil insurrection

this section contains:

leaving fallon community health plan

ineligibility for you or a dependent

A subscriber's group membership may end because he or she:

- Is terminated from employment
- Leaves a job
- Loses coverage due to a reduction in work hours
- No longer lives in the FCHP Select Care service area

A dependent's membership may end because of

- Attainment of age 26 or two years after the end of the calendar year in which the dependent last qualified as a depedent under 26 U.S.C. 106, whichever occurs first.
- Divorce
- Loss of the subscriber's eligibility

Dependent coverage under the plan will cease on the last day of the month when a family member no longer qualifies as a dependent under the rules and regulations of the GIC or applicable state law. (e.g., attainment of age 26 or two years following loss of dependent status under IRS guidelines, whichever comes first, loss of eligibility due to divorce).

If a subscriber's group coverage ends, the subscriber and any dependents may have a right to choose continued group coverage to the extent required by state and federal law. Contact your plan sponsor for information on eligibility and continued enrollment. (For more information about continuation of coverage once you are no longer eligible through your group, or conversion to a consumer plan, see **conversion options**.)

cancellation by fchp

You do not have to worry that FCHP will cancel your coverage because you are using services or because you will need more services in the future. We will cancel coverage only for the following reasons:

- You no longer live in the FCHP Select Care service area. Notify the GIC within 60 days of the date you move.
- You made some misrepresentation or you conspired with another party to defraud the plan. An example is an incorrect or incomplete statement on your application form that indicated that you were eligible for coverage when you were not. In such a case, cancellation will be as of your effective date or other date we determine appropriate. We will refund the premium charge you have paid if applicable. Any payments made for claims under this contract will be subtracted from the refund. If we have paid more for claims under this contract than you have paid in premium charges, we have the right to collect the excess from you. In any case of misrepresentation, the health plan may deny enrollment to you in the future.
- Your premium charge is not paid within the grace period appropriate for your health plan. (See **how your coverage works** for information about grace periods and nonpayment of premium.) The plan will notify you of the effective date of the cancellation, in accordance with Massachusetts insurance regulations.
- You commit an act of physical or verbal abuse that poses a threat to a plan provider, a plan employee or another plan member. In such an instance, we must determine that the act of abuse was not related to your physical or mental condition.

- The GIC cancels its group service agreement with FCHP. In the event that your group coverage is canceled because the GIC fails to pay the premium charge to us, you may apply for short-term (60-day) conversion coverage. To apply for this coverage, send us a written request within 60 days of the day you receive our notice of the group's cancellation. The 60-day conversion coverage will be available at the same cost and coverage level as you previously had under your group coverage. At the end of your 60-day conversion coverage, if you would like to remain an FCHP member, you can join a consumer plan. (See **changing to a consumer plan** for more information.)

In accordance with state law, FCHP will not require genetic testing or the submission of genetic information as a condition of initial or continued enrollment. We will not discriminate or make any distinction among members based on any genetic test or information.

involuntary member cancellation rate

For the calendar year 2007, FCHP's involuntary cancellation or disenrollment rate was 0.0%. The involuntary disenrollment rate includes any members disenrolled by the plan due to misrepresentation or fraud on the part of the member or the commission of acts of verbal or physical abuse. For calendar year 2007, FCHP's voluntary disenrollment rate was 0.8%.

disenrollment by the subscriber

To cancel your contract, the subscriber or the GIC must give us notice in writing 30 days prior to cancellation. If the premium charge is paid for a period beyond the cancellation date, we will refund the premium charge for that period. If the subscriber or the GIC cancels the

contract, we will not provide benefits for services, supplies or medication received after the cancellation date.

eligibility for medicare

If you are a member age 65 or older, your eligibility may change in one of the ways shown below.

- If you are employed after age 65, you and your dependents may remain covered under this contract as long as you are an active employee.
- If you become eligible for Medicare and you are no longer employed, you are no longer eligible for coverage under this contract. You may be eligible for enrollment in Fallon Senior Plan™, our Medicare Advantage product, either through the GIC or directly with Fallon Community Health Plan. To enroll, you must have both Medicare Part A and Part B, live in the Fallon Senior Plan™ service area and pay the premium charge when applicable. Please contact our Customer Service Department for more information.
- If you are not eligible for Medicare upon reaching age 65, you may continue to be covered under this contract.

Once you have retired and become eligible for Medicare, you may elect to continue with the plan through Fallon Senior Plan.™ You may join Fallon Senior Plan™ even if enrollment is closed to the general public. To enroll, you must have both Medicare Part A and Part B and live in the Fallon Senior Plan™ service area and pay the premium charge when it's due. If you have a spouse and/or dependents who were covered under your group membership before you turned 65, they may continue coverage in that group for as long as they are eligible.

changing to other health insurance

As long as the GIC agrees, you may change your coverage to any other health benefits plan offered where you work. You may do this within 30 days of any of the following:

- The anniversary date of your group. There will generally be an open enrollment period preceding your group's anniversary date, during which you can arrange for changes that will be effective on the anniversary date. There also may be a special enrollment period determined by FCHP and your group.
- The day you move to a place outside the FCHP Select Care service area
- The date you become eligible to enroll in another federally qualified health maintenance organization within the FCHP Select Care service area for which you were not formerly eligible because of where you live
- The date we are no longer a part of the health benefits plan offered where you work
- The date the plan stops operation

Please note: Nothing in this section changes the application of the coordination of benefits between the plan and any other health benefits plan.

obtaining a certificate of creditable coverage

If you cancel your enrollment with FCHP, we will send you a HIPAA Certificate of Creditable Coverage, free of charge. This certificate gives you proof of continued coverage that can help you obtain other coverage without a pre-existing condition clause. You may request additional copies of the certificate by calling Customer Service.

your hipaa portability rights

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance (1-617-521-7777) or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272.

Using Certificates of Creditable Coverage to reduce pre-existing condition exclusion waiting periods

Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as 'pre-existing condition exclusions,' apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under

HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior 'creditable' coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare, and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage).

When you have the right to specially enroll in another plan

If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. **Therefore, should you have**

such a life event or your coverage end, you should request special enrollment in another plan as soon as possible if you are eligible for it.

You have the right not to be discriminated against based on health status

A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When you have the right to individual coverage

If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (shown on this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premium;
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

this section contains:

conversion options

group health continuation coverage under COBRA

It is important that you read this notice **if your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends**.

You must complete a GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by mailing it to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 1-617-727-2310, or write to the GIC at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at www.dol.gov/ebsa.

what is COBRA coverage?
COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

who is eligible for COBRA coverage?
Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee covered by the GIC's Health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth, Municipality, or other entity ends for any reason

other than gross misconduct or his/her hours or employment are reduced; or
- You and your spouse divorce or legally separate.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):
- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents divorce or legally separate; or
- Attainment of age 26 or two years following loss of dependent status under IRS guidelines, whichever occurs first.

how long does COBRA coverage last?
By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage. You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period

ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid **in full** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- Your employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

how and when do i elect COBRA coverage?
Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

how much does COBRA coverage cost?
Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

how and when do i pay for COBRA coverage?
If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but you are responsible for paying for the coverage even if you do not receive a monthly statement. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end

of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.

can i elect other health coverage besides COBRA?
Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The GIC has no involvement in conversion programs, and you pay premium to the health plan for the conversion coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

your COBRA coverage responsibilities

- You must inform the GIC of any address changes to preserve your COBRA rights;
- You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day

grace period after the due date on the bill, your COBRA coverage will end.

- You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:
- The employee's job terminates or his/her hours are reduced;
- The employee or former employee dies;
- The employee divorces or legally separates;
- The employee or employee's former spouse remarries;
- A covered child ceases to be a dependent;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage**.** To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

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family and medical leave act

Under the Family and Medical Leave Act, you may be able to take up to 12 weeks of unpaid leave from your employment due to certain family or medical circumstances. Contact your plan sponsor to find out if you qualify. If you do, you may continue group health coverage during your leave, but you must continue to pay the portion of the premium that you would pay if you were actively working. Your coverage will be subject to suspension or cancellation if you fail to pay your premium on time. (See **how your coverage works**.) If you take a leave and group coverage is cancelled for any reason during your leave, you may resume coverage when you return to work without waiting for an open enrollment period.

changing to a consumer plan

If your eligibility for health insurance coverage through the GIC ends, you may be eligible to join a consumer plan. Contact FCHP at 1-888-PWR-FCHP to find out more about the options available to you. You may not convert to a consumer plan if your group coverage ended because of fraud on your part.

this section contains:

fallon community health plan select care service area

Please note: When you are outside the FCHP Select Care service area, you are only covered for emergency and urgent care services.

The FCHP Select Care service area includes all of Berkshire, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Suffolk and Worcester Counties, and parts of Bristol and Plymouth Counties. The communities listed below are included.

Abington
Acton
Adams
Agawam
Alford
Allston
Amesbury
Amherst
Andover
Arlington
Ashburnham
Ashby
Ashfield
Ashland
Ashley Falls
Assonet
Athol
Attleboro
Auburn
Auburndale
Avon
Ayer
Baldwinville
Barre
Becket
Bedford
Belchertown
Bellingham
Belmont
Berkley
Berkshire
Berlin
Bernardston
Beverly
Billerica
Blackstone
Blandford
Bolton
Bondsville
Boston
Boxborough
Boxford
Boylston
Braintree
Bridgewater
Brighton
Brimfield
Brockton
Brookfield
Brookline
Buckland
Burlington
Cambridge
Canton
Carlisle
Charlemont
Charlestown
Charlton
Chelmsford
Chelsea
Cherry Valley
Cheshire
Chester

Chesterfield
Chestnut Hill
Chicopee
Clarksburg
Clinton
Cohasset
Colrain
Concord
Conway
Cummington
Dalton
Danvers
Dedham
Deerfield
Dighton
Dorchester
Douglas
Dover
Dracut
Drury
Dudley
Dunstable
Duxbury
East Boston
East Bridgewater
East Brookfield
East Douglas
East Longmeadow
East Otis
East Taunton
East Walpole
Easthampton
Easton
Egremont
Erving
Essex
Everett
Fall River
Feeding Hills
Fiskdale
Fitchburg
Florence
Florida
Foxborough
Framingham
Franklin
Freetown
Gardner
Georgetown
Gilbertville
Glendale
Gloucester
Goshen
Grafton
Granby
Granville
Great Barrington
Greenfield
Groton
Groveland
Hadley
Halifax
Hamilton
Hampden
Hancock
Hanover
Hanson
Hardwick
Harvard
Hatfield
Haverhill
Haydenville
Heath
Hingham
Hinsdale
Holbrook
Holden
Holland
Holliston
Holyoke
Hopedale
Hopkinton
Housatonic
Hubbardston
Hudson
Hull
Huntington
Hyde Park
Indian Orchard
Ipswich
Jamaica Plain
Jefferson
Kingston
Lake Pleasant
Lakeville
Lancaster
Lanesborough
Lawrence
Lee
Leeds
Leicester
Lenox
Lenox Dale
Leominster

Leverett
Lexington
Lincoln
Littleton
Longmeadow
Lowell
Ludlow
Lunenburg
Lynn
Lynnfield
Malden
Manchester
Mansfield
Marblehead
Marlborough
Marshfield
Mattapan
Maynard
Medfield
Medford
Medway
Melrose
Mendon
Merrimac
Methuen
Middleborough
Middlefield
Middleton
Milford
Mill River
Millbury
Millis
Millville
Milton
Monroe Bridge
Monson
Montague
Monterey
Mount Washington
Nahant
Natick
Needham
New Ashford
New Braintree
New Marlborough
New Salem
New Salem
Newbury
Newburyport
Newton
Norfolk
North Adams
North Amherst
North Andover
North Attleborough
North Billerica
North Brookfield
North Chelmsford
North Dighton
North Easton
North Grafton
North Hatfield
North Oxford
North Reading
Northampton
Northborough
Northbridge
Northfield
Norton
Norwell
Norwood
Oakham
Orange
Otis
Oxford
Palmer
Paxton
Peabody
Pembroke
Pepperell
Peru
Petersham
Phillipston
Pittsfield
Plainfield
Plainville
Plympton
Princeton
Quincy
Randolph
Raynham
Reading
Rehoboth
Revere
Richmond
Rochdale
Rockland
Rockport
Roslindale
Rowe
Rowley

Roxbury
Royalston
Russell
Rutland
Salem
Salisbury
Sandisfield
Saugus
Savoy
Scituate
Seekonk
Sharon
Sheffield
Shelburne Falls
Sherborn
Shirley
Shrewsbury
Shutesbury
Somerset
Somerville
South Boston
South Deerfield
South Easton
South Egremont
South Grafton
South Hadley
South Hamilton
South Lee
South Walpole
Southampton
Southborough
Southbridge
Southfield
Southwick
Spencer
Springfield
Sterling
Stockbridge
Stoneham
Stoughton
Stow
Sturbridge
Sudbury
Sunderland
Sutton
Swampscott
Swansea
Taunton
Templeton
Tewksbury
Thorndike
Three Rivers
Topsfield
Townsend
Turners Falls
Tyngsborough
Tyringham
Upton
Uxbridge
Waban
Wakefield
Wales
Walpole
Waltham
Ware
Warren
Warwick
Washington
Watertown
Wayland
Webster
Wellesley
Wendell
Wendell Depot
Wenham
West Boylston
West Bridgewater
West Brookfield
West Chesterfield
West Hatfield
West Newbury
West Newton
West Roxbury
West Springfield
West Stockbridge
West Townsend
Westborough
Westfield
Westford
Westminster
Weston
Westwood
Weymouth
Whately
Whitinsville
Whitman
Wilbraham
Williamsburg
Williamstown
Wilmington
Winchendon
Winchester

Windsor
Winthrop
Woburn
Worcester
Woronoco
Worthington
Wrentham

your costs for covered services

The following section contains a description of your covered services as a member of FCHP, including any limitations or exclusions related to each specific benefit. Please note: Our **general exclusions and limitations** section contains additional limitations that you should be aware of.

Covered services are health care services or supplies for which the plan will pay benefits. A service is covered according to the terms and conditions described in this *Member Handbook/Evidence of Coverage* only if it is medically necessary, provided by your PCP or another network provider (except in emergency situations), and in some cases, authorized by the plan. The following section describes your costs for the benefits that you use.

copayment maximum

You are responsible for a maximum of four inpatient copayments per member in each calendar year, and four outpatient surgery copayments per member in each calendar year. (Note that if you are re-admitted within a 30-day period, we will waive the second copayment.)

FCHP will track the copayments that apply to the calendar year limit. When you reach the maximum for any service, we will send you a letter that indicates the date of the last required copayment for that service. For the rest of the calendar year, you may present a copy of the letter to the cashier who will not take a copayment for the specified services. If you do not bring the letter with you to the appointment, you may be asked to pay the copayment. If you pay any copayments that you are not responsible for, you may send a letter to the Claims Manager at FCHP

requesting reimbursement of those copayments. Include your name, address, membership number, proof of payment (encounter form, receipt, check, etc.) and an address to which the reimbursement should be sent. You must file a claim within two years of the date of service.

coinsurance

Coinsurance is your share of the allowed charge for certain covered benefits, usually expressed as a percentage. For example, if your coinsurance amount is 20%, you pay 20% of the allowed charges for the purchase or rental of covered durable medical equipment you receive, and the plan pays the remaining 80%.

As a member of this plan, you are responsible for coinsurance the following:

- Durable medical equipment
  Plan pays: 80% of the purchase price or rental cost;
  You pay: 20% of the purchase price or rental cost.
- Hearing aids (once per two-year period)
  Plan pays: 100% of the first $500 of the purchase price; and 80% of the next $1,500 of the purchase price;
  You pay: 20% of the purchase price between $501 and $2,000 plus all additional costs.

ambulance

emergencies:

In emergencies, where a prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm, the plan covers ambulance transportation from the place where a person is injured or stricken by illness to the nearest hospital where treatment can be given. Call your local emergency communications system (e.g., police or fire department, or 911) to request an ambulance. For more information about emergency situations, see **emergency and urgent care**.

Emergency services do not require referral or authorization, but you must notify the plan of any emergency services that you receive. (See **emergency care**.) The type of ambulance used (air ambulance, land ambulance, etc.) must be appropriate to medical and geographic conditions. Note: You may be responsible for additional costs if you specifically request a form of ambulance transport that the plan deems inappropriate for your situation.

Non-emergency situations:

Ambulance service for medical treatments and procedures may be provided for certain nonemergency situations, when medically necessary. Any such services must be referred by a plan physician and authorized by the plan prior to the transportation date or occurrence. Transportation by any other means must be contraindicated by your medical condition in order to be considered for potential authorization approval.

Non-emergency transportation may also be considered if a member requires a medically necessary treatment or procedure and is nonambulatory both before and after the ordered treatment or procedure. Chair van or medivan transportation may be authorized in lieu of ambulance transportation if criteria are met for consideration of transportation approval. We reserve the right to determine the appropriate vehicle that meets criteria for transportation.

service

1. Ambulance transportation for an emergency
2. Ambulance transportation for preauthorized non-emergency transfers

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Ambulance, chair van and/or medivan use for patient convenience, nonclinical reasons, or transportation services only, including elective chair van transport from long-term care facilities to medical appointments
2. Transfers between hospitals when your medical condition does not warrant that you be transported to another facility
3. Transportation that can be planned ahead of time to or from a doctor's office, clinic or other place for medical care
4. Air ambulance, when not appropriate to medical or geographic conditions
5. Commercial airline transportation

durable medical equipment and prosthetic/orthotic devices

The plan covers durable medical equipment and prosthetic/orthotic devices as described below. The plan pays 80% for most covered items, and you are responsible for the remaining 20%. Hearing aids and scalp hair prostheses (wigs) are subject to calendar year maximums.

Most services require referral and authorization. (See **obtaining specialty care and services** for more information.)

Durable medical equipment is defined as an item for external use that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Durable medical equipment includes, but is not limited to, such items as:

- Oxygen
- Oxygen equipment
- Respiratory equipment
- Hospital beds
- Wheelchairs
- Crutches, canes and walkers
- Breast pumps
- Blood glucose monitors for home use, for the treatment of diabetes
- Insulin pump and insulin pump supplies

- Visual magnifying aids and voice synthesizers for blood glucose monitors, for use by diabetics who are legally blind

Prosthetic devices are devices that replace all or part of an organ or body part (other than dental). Some examples are:

- Artificial limbs and eyes
- Implanted corrective lenses needed after a cataract operation
- Breast and hair prosthesis
- Electric speech aids

Orthotic devices are "rigid or semi-rigid" devices that support part of the body and/or eliminate motion. Some examples are:

- A form neck collar for cervical support
- A molded body jacket for curvature of the spine (scoliosis)
- An elbow or leg brace
- Back, neck or leg braces with rigid supports, including orthopedic shoes that are part of braces
- Splints
- Therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease

service

1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices. Includes the fitting, preparing, repairing and modifying of the appliance.
2. Hearing aid(s) when prescribed by a plan physician and obtained from a network provider. Coverage is limited to once in each two-calendar year period.

3. Scalp hair prostheses (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for up to $350 per member per calendar year when the prosthesis is determined to be medically necessary by a plan physician and the plan.
4. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy
5. Oxygen and related equipment
6. Insulin pump and insulin pump supplies. These items are covered in full.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Scalp hair prosthesis in excess of $350 per member per calendar year or for medical conditions other than those described above
2. Items that are not covered include, but are not limited to:
   - Air conditioners, air cleaners or purifiers, dehumidifiers, humidifiers, HEPA filters and other filters, and portable nebulizers
   - Arch supports, foot orthotics or orthopedic shoes (except when part of a brace or for diabetic foot care) or other supportive devices for the feet
   - Articles of special clothing, mattress and pillow covers, including hypoallergenic versions
   - Bed pans and bed rails
   - Bidets, bath and/or shower chairs
   - Comfort or convenience items such as telephone arms and over-bed tables

- Dentures
- Ear plugs (such as to prevent fluid from entering the ear canal during water activities or for sound/noise control)
- Elevators, ramps, stair lifts, chair lifts, strollers and scooters
- Eyeglasses and contact lenses
- Heating pads, hot water bottles and paraffin bath units
- Home blood pressure monitors and cuffs
- Any home adaptations, including but not limited to, home improvement and home adaptation equipment
- Hot tubs, saunas, Jacuzzis, swimming pools or whirlpools
- Incontinence products
- Items that are considered experimental, investigational, or not generally accepted in the medial community
- Items not listed, or listed as "not covered," on the durable medical equipment (DME) and medical and surgical supplies list
- Items that do not meet the coverage criteria previously listed
- Venous pressure stockings (such as TEDS or Jobst® stockings)
- Raised toilet seats
- Safety equipment, such as grab bars, car seats, seizure helmets, safety belts or harnessess, or vests
- Alcohol and alcohol wipes

3. Oxygen and related equipment, when obtained from a non-plan provider. This includes oxygen and related equipment that you are supplied with while you are out of the FCHP Select Care service area.
4. Services that are not determined to be medically necessary. This applies even if the plan calendar year limits have not been reached.
5. Charges for hearing aids in excess of $1700, with the first $500 covered at 100% and the next $1500 covered at 80%.

emergency and urgent care

emergency care

The plan covers emergency care worldwide. When you have an emergency medical condition, you should go to the nearest emergency room for care or call your local emergency communications system (e.g., police or fire department, or 911).

An emergency medical condition is a condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in:

1. serious jeopardy to the health of the member or another person (or unborn child),
2. serious impairment to bodily functions, or
3. serious dysfunction of any bodily organ or part.

Examples of covered emergencies include, but are not limited to, stroke, unconsciousness, heart attack symptoms or severe bleeding.

Emergency services do not require referral or preauthorization, but you must notify the plan of any emergency services that you receive. Your PCP should be notified so that arrangements can be made for any follow-up or continuing care that is medically necessary for you. You should be aware that follow-up care in an emergency room often will not meet a prudent layperson definition and that most emergency room follow-up care can be provided in a setting other than an emergency room.

urgent care

Sometimes you may need care right away for minor emergencies such as cuts that require stitches, a sprained ankle or abdominal pain. These situations may not pose as much of a threat as the emergency situations discussed above, but they still require fast treatment to prevent serious deterioration of your health.

If you are within the FCHP Select Care service area, call your PCP's office for information on how and where to seek treatment. If your doctor is not available, an on-call doctor will make arrangements for your care. Telephones are answered 24 hours a day seven days a week. Explain the medical situation to the doctor and state where you are calling from, so that the doctor can refer you to the most appropriate facility. You may also call the Fallon Clinic Urgent Care Department directly for an appointment for urgent care services *if you have a Fallon Clinic PCP*.

If you are outside the FCHP Select Care service area, go to the nearest medical facility for care. If you need follow-up care, you should contact your PCP for assistance.

service

1. Emergency room visits
2. Emergency room visits when you are admitted to an observation room
3. Emergency room visits when you are admitted as an inpatient
4. Urgent care visits in a provider's office or at an urgent care facility
5. Emergency prescription medication provided out of the FCHP Select Care service area as part of an approved emergency treatment

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Nonemergency care provided in an emergency room
2. Unauthorized in-area urgent care visits (unless received at the Fallon Clinic Urgent Care Department *and you have a Fallon Clinic PCP)*
3. Out-of-area care or services that could have been anticipated before leaving the FCHP Select Care service area
4. Follow-up care, unless provided by your PCP, a Fallon Clinic specialist *if you have a Fallon Clinic PCP*, or authorized by the plan. This exclusion includes follow-up care in an emergency room setting.
5. Nonemergency prescription medication outside the FCHP Select Care service area such as medication for a chronic condition or a maintenance supply. You may use the prescription medication mail-order program to fill medication refills. (See **prescription medication**.)
6. Care from a non-plan or out-of-area provider once you are medically able to return to the service area

home health care services

The plan covers medically necessary skilled home health care services provided in conjunction with a plan physician-approved home health services plan. These skilled services are provided in your home by a licensed home health care agency. A hospital, skilled nursing or rehabilitation facility is not considered to be the home. Skilled services include nursing, physical therapy, occupational therapy and speech therapy.

Covered services include: (In order to receive any of the below services, you must also require at least one of the above services—skilled nursing, physical therapy, occupational therapy and/or speech therapy—at the same time.)

- Medical social services
- Services of a home health aide or nutritionist
- Durable medical equipment and supplies ordered by your physician for the treatment and diagnosis of your injury. See **durable medical equipment and prosthetic/orthotic devices** for more information on durable medical equipment coverage and exclusions. Please note that durable medical equipment provided as part of your home health care services is not subject to a coinsurance payment.

Home health care services must be ordered by a plan physician and authorized by the plan. See **obtaining specialty care and services** for more information. Members receiving skilled services must meet the homebound criteria.

service

1. Skilled nursing care
2. Physical, occupational and speech therapy
3. Medical social services
4. Home health aide services
5. Medical and surgical supplies and durable medical equipment
6. Nutritional consultation
7. Certain injectable medications that are administered in the home setting, when approved by FCHP and received through a plan-approved pharmacy vendor

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Personal comfort items
2. Meals
3. Housekeeping services and/or homemaking services
4. Custodial care services and/or unskilled home health care, whether at home or in a facility setting

hospice care

The plan covers licensed hospice services for terminally ill members. Hospice is a type of care that emphasizes supportive services in a home setting and pain control, rather than the cure-oriented services provided in hospitals.

Hospice services may include, but are not limited to, physician's services; nursing care provided by or under the supervision of a registered professional nurse; dietary, occupational, physical and speech therapy for purposes of symptom control or to enable the individual to maintain activities of daily living; home health aides to assist with personal care; medical supplies and appliances; medical social services; counseling services provided by professional or volunteer staff under professional supervision; volunteer services and respite care.

Hospice care services require a referral from your PCP and plan authorization. (See **obtaining specialty care and services** for more information.)

service

1. Nursing care provided by or under the supervision of a registered professional nurse (includes services provided by a home health aide)
2. Medical social services provided by a social worker
3. Outpatient physicians' services provided by a doctor of medicine or doctor of osteopathy
4. Counseling services, such as dietary or bereavement, provided to the terminally ill individual and the family members or other persons caring for the individual at home

5. Short-term inpatient* care for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting.

   * Limited to four copayments per calendar year. If you are re-admitted within a 30-day period, we will waive the second copayment.

6. Medical appliances and supplies
7. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills
8. Prescription medication that is related to the terminal illness of the individual

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Long-term rehabilitative care
2. Hospice care services not authorized by the plan

hospital inpatient services

The plan covers inpatient care for as many days as your condition requires. Your plan provider will work with the plan's Care Coordination Department to develop a treatment plan for you.

If you are in a hospital or other medical facility when your coverage takes effect, you will be covered by the plan as of your effective date as long as you notify us as soon as medically possible that you are an inpatient. You must also allow a plan physician to assume further care. If medically appropriate, you may be transferred to a plan facility.

Hospital inpatient services require referral and authorization. (See **obtaining specialty care and services** for more information on referral and authorization.) Whenever you need to be admitted to a hospital for a medical procedure, your PCP and specialty care physician will work with us to obtain authorization at a plan facility to which your physician admits. Your physician and the plan will also monitor the care that you receive as an inpatient and coordinate your discharge from the hospital. While you are an inpatient, our case management program will review and evaluate the inpatient care that you receive to make sure that you receive appropriate care. For more information about case management review, see the **utilization review** section.

service

1. Room and board in a semiprivate room or a private room when medically necessary*

   * Limited to four copayments per calendar year. If you are re-admitted within a 30-day period, we will waive the second copayment.

2. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, diagnostic lab, pathology and X-ray services; anesthesia services; short-term rehabilitation; and operating and recovery room services.
3. Physician and surgeon services
4. General nursing services
5. Intensive and/or coronary care
6. Dialysis services
7. Medical, surgical or psychiatric services
8. Nursing services provided by a certified registered nurse anesthetist

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Private room, unless medically necessary. If you desire a private room and it is not a medical necessity, you pay all additional room charges above the semiprivate room charge.
2. Personal comfort items such as telephone, radio or television
3. Charges that you incur for services not determined to be medically necessary by a plan physician and the plan, or when you choose to stay beyond the hospital discharge hour for your own convenience

4. Rest or custodial care, or long-term care
5. Autologous blood donation or storage for use during surgery or other medical procedures
6. Unskilled nursing home care

infertility/assisted reproductive technology services

The plan covers medically necessary services for the diagnosis and treatment of infertility. Infertility is defined as: "The condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year." To meet coverage criteria, among other factors, (1) you must be an individual in whom fertility would naturally be expected, and (2) for females, you must be premenopausal or experiencing menopause at a premature age. Approval for coverage of assisted reproductive technology (ART) is contingent upon review by the FCHP medical director. FCHP's coverage guidelines for all ART services are available by contacting the Customer Service Department.

Infertility services require referral and authorization unless provided by a Fallon Clinic specialist (if you have a Fallon Clinic PCP). Certain fertility medications also require authorization; some may have a quantity limit for each prescription as well. See **obtaining specialty care and services** for more information on referral and authorization.

service

1. Office visits for the consultation, evaluation and diagnosis of infertility
2. Diagnostic laboratory and X-ray services
3. Artificial insemination, such as intrauterine insemination (IUI)
4. Assisted reproductive technologies including, but not limited to:

a. In vitro fertilization (IVF-EP)
b. Gamete intrafallopian transfer (GIFT)
c. Zygote intrafallopian transfer (ZIFT)
d. Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility or when preimplantation genetic diagnosis (PGD) testing is covered
e. PGD when the partners are known carriers for certain genetic disorders

5. Sperm, egg, and/or inseminated egg procurement, processing and banking, to the extent that such costs are not covered by the donor 's insurer

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Services that are considered experimental or investigational.
2. Services for a member who is not medically infertile.
3. Services for a partner who is not a member.
4. Services for women who are menopausal, except those women who are experiencing premature menopause.
5. Donor sperm
   a. In the absence of documented male factor infertility, as evidenced by abnormal semen analysis.
   b. In men with genetic sperm defects.
6. Chromosome studies of a donor (sperm or egg).

7. Preimplantation genetic diagnosis (PGD) for aneuploidy screening or other indications not listed above under **service.**
8. Gender selection in the absence of a documented X-linked disorder.
9. Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity.
10. Transportation costs to and from the medical facility
11. Treatment to reverse voluntary sterilization.
12. Infertility services that are necessary as a result of a prior voluntary sterilization in the absence of a successful reversal procedure.
13. Supplies that may be purchased without a physician's written order, such as ovulation test kits.
14. Services related to achieving pregnancy through a surrogate or gestational carrier.
15. Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved series of infertility cycles.
16. Service fees, charges or compensation for the recruitment of egg donors (this exclusion does not include the charges related to the medical procedure of removing an egg for the purpose of donation when the recipient is a member of the plan).
17. Sperm, egg and/or inseminated egg procurement, processing and banking of sperm or inseminated eggs, to the extent such costs are covered by the donor's insurer.

maternity services

The plan covers maternity and obstetrical services in accordance with the General Laws of Massachusetts. Routine obstetrical and maternity care does not require a referral or authorization, but you need to see a plan provider who is an obstetrician, certified nurse midwife or family practice physician. See **obtaining specialty care and services** for more information.

service

1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care
2. Inpatient maternity and newborn child care for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery. The covered length of stay may be reduced if the mother and the attending physician agree upon an earlier discharge. If you or your newborn are discharged earlier, you are covered for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however that the first home visit shall be conducted by a registered nurse, physician or certified nurse midwife; and provided further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider
3. Charges for the following services when provided during an inpatient maternity admission: childbirth, nursery charges, circumcision, routine examination, hearing screening, and medically necessary treatments of congenital defects, birth abnormalities or

premature birth.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Routine maternity care when you are traveling outside the plan service area. This includes prenatal, delivery and admission, and postpartum care
2. Delivery outside the plan service area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery
3. Routine circumcision performed after an infant's discharge from a maternity hospital admission (unless determined to be medically necessary prior to discharge)
4. Charges for a home birth

mental health

The plan covers the diagnosis and treatment of mental conditions on an outpatient or inpatient basis. A mental condition is defined as a condition that is described in the most recent edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association, and that is determined as such by a plan provider and the plan. The level of care needed and the program used must be authorized by a plan psychiatrist. Treatment may be provided by a psychiatrist, psychologist, psychotherapist, licensed nurse mental health clinical specialist, licensed independent clinical social worker, mental health counselor, pediatric specialist or other provider as authorized by the plan.

A member who loses eligibility as a dependent upon reaching age 19 and is receiving ongoing mental health treatment at the time may be eligible to continue coverage for the treatment. Call Customer Service for more information. (Members who lose eligibility as a dependent may also continue full coverage under COBRA, see **conversion options**.)

For mental health emergencies, follow the same procedures as for any other medical emergency, as outlined in **emergency and urgent care**.

inpatient services

The plan covers mental health services in an inpatient or alternative (diversionary) setting, when authorized by the plan. To access services and obtain authorization, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). Unlimited coverage is provided for inpatient care when medically

necessary in a licensed or accredited general hospital, or in a licensed or accredited psychiatric hospital (or its equivalent in an alternative program). Levels vary from least to most restrictive and include: respite or crisis stabilization, day or evening treatment or partial hospitalization, short-term residential treatment and hospital-based programs.

service

1. Room and board in a semiprivate room (or a private room when medically necessary) for respite, short-term residential, and hospital care only
2. The treatments and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, family and group therapy, pharmacotherapy and diagnostic laboratory services.
3. Professional services provided by physicians or other licensed mental health professionals for the treatment of psychiatric conditions

intermediate services

Members may receive mental health care in an alternative setting in lieu of inpatient hospitalization. This may include, but is not limited to, day and evening treatment programs.

service

1. Diversionary services such as day treatment/evening treatment and/or partial hospitalization for a full or partial day. Any of these services require authorization from the plan.

outpatient services

Members may self-refer for outpatient mental health services. For assistance in finding a network provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). The plan covers medically necessary mental health services of a network provider, in an outpatient setting, as follows:

service

1. Outpatient office visits, including individual, group or family therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group or family therapy.
2. Psychopharmacological services, such as visits with a physician to review, monitor or adjust the levels of prescription medication used to treat a mental condition
3. Neuropsychological assessment services, when medically necessary

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Treatment for personal growth, or other treatment that is not medically necessary
2. Evaluation and therapy for central auditory processing difficulties
3. Sensory integration therapy
4. Alternative therapies such as biofeedback, neurofeedback, and telephone, herbal, art, massage (when not provided by a physician or physical therapist) or music therapy

5. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling and training, or educational therapy for learning disabilities
6. Psychological testing or neuropsychological assessments unless determined to be medically necessary
7. Elective long-term psychotherapy
8. Mediation or intervention services
9. Faith-based counseling (e.g., Christian counseling)

office visits and outpatient services

The plan provides coverage for the services listed below. Pediatric specialty care, including mental health care, is covered when provided to a member requiring such services by a provider with recognized expertise in specialty pediatrics.

You may self-refer to your PCP. You may self-refer to any Fallon Clinic specialist (physician, physician assistant, or nurse practitioner) if you have a Fallon Clinic PCP. Specialty services with a specialist other than a Fallon Clinic specialist generally require referral and authorization. See **obtaining specialty care and services** for more information on referral and authorization.

The plan covers the costs for services furnished to members enrolled in certain qualified clinical trials to the same extent as they would be covered if the member did not receive care in a qualified clinical trial. To be eligible for coverage, you must have been diagnosed with cancer, and the clinical trial must be one that is intended to treat cancer. Coverage for services provided to you while you are enrolled in the clinical trial is subject to all the terms and conditions of the plan, including, but not limited to, provisions requiring the use of FCHP Select Care providers.

service

office visits and related services

1. Office visits to diagnose or treat an illness or an injury
2. A second opinion, upon your request, with another plan provider

3. Injections and injectables that are included in the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider
4. Allergy injections
5. Radiation therapy
6. Respiratory therapy
7. Hormone replacement services in the doctor's office for perimenopausal and postmenopausal women
8. Audiological examination for the purpose of prescribing a hearing aid. Coverage is limited to one exam every two years.

Diagnostic lab and x-ray services

9. Diagnostic lab and X-ray services ordered by a plan provider, in relation to a covered visit

Chiropractic services

10. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 20 visits in each calendar year. The actual number of visits provided is based on medical necessity as determined by your plan provider the plan.

Renal dialysis

11. Outpatient renal dialysis or continuous ambulatory peritoneal dialysis

Diabetic services

12. Diabetes outpatient self-management training and

education, including medical nutrition therapy, provided by a certified diabetes health care provider

13. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbA1c, tests, and urinary protein/microalbumin and lipid profiles

Medical social services

14. Medical social services provided to assist you in adjustment to your illness or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.

Voluntary family planning services

15. Voluntary family planning services including:
    - Consultations, examinations, procedures and medical services related to the use of all contraceptive methods; reproductive health education and disease prevention; genetic counseling; and elective sterilization
    - Contraceptive devices that are supplied by an FCHP Select Care provider during an office visit
    - Termination of pregnancy in an office setting

    (Note: Termination of pregnancy or other procedures provided in a hospital outpatient, day surgery or ambulatory care facility are subject to the outpatient surgery copayment.)

Outpatient (day) surgery

16. Same-day surgery in a hospital outpatient department or ambulatory care facility*

    * Limited to four copayments per calendar year.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Services required by a third party or court order. Examples are employment, school, sports, premarital and/or summer camp examinations or tests, and any immunizations required by an employer, related to your job and/or work conditions.
2. Acupuncture or massage (when not performed by a physician or physical therapist) therapy
3. Visits to additional providers beyond a second opinion, or a second opinion with a non-plan provider.

oral surgery and related services

The plan covers the services listed below. All services must be provided by a plan oral surgeon or plan physician (this does not include a plan general dentist).

You do not need a referral or authorization for extraction of impacted teeth or for emergency care. All other services shown below require referral and authorization. (See **obtaining specialty care and services** for more information on referrals and authorization.)

service

1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon
3. Treatment of fractures of the jaw bone (mandible) or any facial bone
4. Evaluation and surgery for the treatment of temporomandibular joint
   disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw
5. Lingual frenectomy
6. Emergency medical care such as to relieve pain and stop bleeding as a result of accidental injury to the sound natural teeth or tissues when provided as soon as medically possible after injury. This does not include restorative or other dental care. You do not need authorization for emergency care. Go to the closest provider.

limited services (as a hospital inpatient or at a surgical day care or ambulatory surgical facility)

Benefits are provided for the following procedures only when you have a serious medical condition that makes it essential that you be admitted to a hospital as an inpatient, or to a surgical day care unit or ambulatory surgical facility as an outpatient, in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease. Refer to **hospital inpatient services** or **office visits and outpatient services** for more details on your benefits.

- Extraction of seven or more teeth
- Gingevectomies (including osseous surgery) of two or more gum quadrants
- Excision of radicular cysts involving the roots of three or more teeth
- Removal of one or more impacted teeth

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Procedures or services related to dental care, including restorative dental care and permanent restoration of injured teeth, except as shown above as covered. Noncovered services also include but are not limited to: root canals, extractions, orthodontia, periodontal surgery, endodontic and prosthodontic services, bonding and devices such as bridges, dentures, implants, crowns or caps.
2. Dental treatments and appliances for the treatment of temporomandibular joint disorder (TMJ)
3. Services that have not been authorized by the plan and a plan physician, or unauthorized services provided by

a non-plan oral surgeon (with the exception of the extraction of impacted teeth or emergency care services as specified above)

4. Dentures and the following procedures, when performed for the preparation of the mouth for dentrues: removal of a torus palatinus, alveoplasty, frenectomy and reconstruction of a ridge
5. Osseointegrated implants or insertion of a core-vent implant
6. Covered services that are performed secondary to a noncovered service
7. Inpatient dental care (as a hospital inpatient or at a surgical day care or ambulatory surgical facility), except as shown above under **limited services**

organ transplant

The plan covers certain human solid organ, bone marrow and stem cell transplants. This includes bone marrow transplant or transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease.

If you are the recipient of a transplant, the services for the donor are covered including the evaluation and preparation, and the surgery and recovery directly related to the donation, except for those services covered by another insurer. If you are the donor and the transplant recipient is not a member of the plan, no coverage is provided for either the recipient or the donor, except for human leukocyte antigen or histocompatibility locus antigen testing described in Service number 4 below.

The transplant must be performed at an affiliated transplant facility, subject to your acceptance into the program. The plan will work with the transplant facility to coordinate your care during the evaluation and transplant process and help to arrange your discharge and follow-up care.

If you want a second opinion the plan will identify another suitable transplant facility. Additional opinions beyond a second opinion are not covered. Transplant services require a referral from your PCP and plan authorization. (See **obtaining specialty care and services** for more information.)

service

1. Office visits related to the transplant
2. Inpatient hospital services, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient*
3. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services
4. Human leukocyte antigen (HLA) or histocompatability locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member

* Your copayment for inpatient admissions will apply to each inpatient admission, including admissions for services related to organ transplants. Limited to four inpatient copayments per calendar year. However, if you are re-admitted within a 30-day period, we will waive the second copayment.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Investigational, experimental or unproven procedures, including but not limited to:
   a. the transplant of partial pancreatic tissue or islet cells
   b. a pancreatic transplant that does not follow a kidney transplant or that is not part of a combined pancreas-kidney transplant
2. Bioartificial transplantation, such as the transplant of a total artificial heart
3. Xenotransplantation, such as the transplant of animal tissues or organs into a human

4. Services for the organ donor that are covered by another insurer
5. Services for an organ donor if the recipient is not a member of the plan
6. Transportation or housing costs for the recipient or donor
7. House cleaning costs incurred in preparation for a transplant recipient's discharge

prescription medication

The plan covers medically necessary prescription drugs according to the requirements and guidelines discussed below.

who can write your prescription

A plan provider or a provider you have seen through an authorized referral can write your prescription.

where you can fill your prescription

You can fill your prescription at a plan pharmacy or through a plan pharmacy mail-order program. (Please note that there are some medications that cannot be mailed and are not available through the mail-order program.) See your *FCHP Select Care Provider Network* directory for a list of plan pharmacies.

the fchp formulary

The FCHP formulary is a list of medications that shows the copayment tier and prior authorization requirements for each medication. We have selected the tiers and determined the criteria for prior authorization based on efficacy and cost-effectiveness.

The FCHP prescription drug formulary has a three-tiered copayment structure. We have selected the tiers based on efficacy and cost-effectiveness. There is a different copayment for each tier.

Coverage of certain drugs is based on medical necessity. For these drugs, you will need prior authorization from the plan. They are noted on the formulary as "PA." Your doctor should request authorization from FCHP, and give us the clinical information that we need to make our

decision, before he or she writes the prescription. We will review the authorization request according to our criteria for medical necessity.

The prescription drug formulary is available at our Web site at www.fchp.org. If you do not have access to our Web site or if you have any questions about the formulary please call Customer Service.

The FCHP formulary may include drugs used for the formulary treatment of cancer or HIV/AIDS, in accordance with state law.

dispensing limitations

Prescription drugs are generally dispensed for up to a 30-day supply. A one-month copayment will be charged for up to a 30-day supply. In some instances, the plan has established dispensing limitations, which may include a quantity limit on certain medications. For maintenance medication you may obtain up to a 90-day supply. We follow FDA, state and federal dispensing guidelines. You generally cannot obtain a refill until most or all of the previous supply has been used.

Please note: Your doctor may prescribe medication in a dose that is not available through the purchase of a single prescription. In these cases, you may need to fill more than one prescription—and pay a copayment for each—to achieve the desired dose.

generic and brand-name drugs

A generic drug is a drug product that meets the approval of the U.S. Food and Drug Administration and is equivalent to a brand-name product in terms of quality and performance. It may differ in certain other

characteristics (e.g., shape, flavor or preservatives). By law, generic drug products must contain identical amounts of the same active drug ingredient as the brand-name product.

You will generally receive a generic drug from plan pharmacies anytime one is available, unless your doctor has directed the pharmacist to only dispense a specific brand-name drug. However, some brand-name drugs do not have a generic equivalent. In both of these cases, you will receive the brand-name drug and will be responsible for the appropriate tiered copayment for that drug.

mail-order prescriptions

You may also get your prescription medication refill(s) through a plan pharmacy mail-order program. You may have your prescription mailed directly to you at home or at any other location if you are traveling within the country. Most medications can be mailed; however, there are some that may not. (Medications cannot be mailed to other countries.)

When you fill your prescription through our mail-order program you may order up to a 90-day supply of most medications. The Tier-1 and Tier-2 mail-order copayment amount is equal to the cost of two retail pharmacy copayments (that is, the amount you would pay for a 60-day supply at a retail pharmacy). The Tier-3 mail-order copayment amount is equal to the cost of two-and-one-quarter retail pharmacy copayments.

new members

If you are a new member and need to have an existing prescription refilled, we encourage you to see your PCP to review your prescriptions. If you are currently taking a

drug for that requires prior authorization by FCHP, your doctor will need to submit a request for prior authorization. We will determine coverage of that drug based on our criteria for medical necessity. If the drug you are currently taking is a Tier-3 drug, you may want to discuss alternatives with your doctor.

covered items: (some of these medications and covered items may require prior authorization)

- Prescription medication
- Contraceptive drugs and devices
- Hormone replacement therapy
- Injectable agents (self-administered*)
- Insulin
- Syringes or needles (including insulin syringes) when medically necessary
- Supplies for the treatment of diabetes, as required by state law, including:
  - —blood glucose monitoring strips
  - —urine glucose strips
  - —ketone strips
  - —lancets
  - —insulin pens, for the treatment of diabetes
- Prescribed oral medications that influence blood sugar levels, for the treatment of diabetes, as required by state law
- Certain injectable medications administered in the home setting, when approved by FCHP and received through a plan-approved pharmacy vendor

* Injectables administered in the doctor's office or under other professional supervision are generally covered as a medical benefit.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Drugs that you can buy without a prescription, including prescription medications that are available as over-the-counter products
2. Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration
3. Drugs that are not used in accordance with FDA-approved labeling, including, but not limited to: unapproved doses, unapproved duration of therapy and unapproved indications
4. Drugs that require prior authorization if prior authorization is not received
5. Drugs prescribed for purposes that are not medically necessary. This includes, but is not limited to, drugs for cosmetic purposes, to enhance athletic performance, for appetite suppression, or for noncovered conditions. This also includes drugs that do not meet medical criteria.
6. Prescriptions obtained within the FCHP Select Care service area at a non-network pharmacy
7. Nonemergency prescriptions filled outside the plan service area
8. Vitamins and minerals, whether or not a prescription is required
9. Over-the-counter birth control preparations or devices
10. Drugs that are prescribed for anything other than the U.S. Food and Drug Administration's approved usage. (This does not include the off-label uses of covered prescription drugs used in the treatment of HIV/AIDS or cancer when used in accordance with

state law. This also does not include bone marrow transplants for breast cancer as required by state law.)

11. Products used for any dental condition that is not covered under your FCHP dental benefit
12. Medications used for preference or convenience
13. Medications that are new to the market that have not been reviewed by FCHP for safety and adverse events. These medications are not covered by FCHP until they have been reviewed and guidelines for their use have been developed. This could take up to 180 days after they are on the market.
14. Replacement of more than one lost/mishandled medication per prescription per calendar year
15. Prescription drugs that are a combination of a covered prescription item and an item that is specifically excluded, such as vitamins, minerals, medical foods or formulas

preventive care

The plan covers the routine and preventive services listed below. Services must be provided or referred by a plan provider. Services do not require referral and authorization unless otherwise indicated. (See **obtaining specialty care and services** for more information on referral and authorization.)

service

1. Periodic physical exams with your PCP for the prevention and detection of disease.
2. Immunizations that are included on the FCHP formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam
5. Routine eye exams, once in each 24-month period
6. Hearing and vision screening performed during a physical exam
7. Well-child care and pediatric services, at least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's 19th birthday. This includes the following services, as recommended by the physician and in accordance with state law:

   - physical examination

- history
- measurements
- sensory screening
- neuropsychiatric evaluation
- development screening and assessment
- appropriate immunizations
- hereditary and metabolic screening at birth
- newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center
- tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis
- lead screening

8. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods
9. Contraceptive devices that are supplied by an FCHP Select Care network provider during an office visit
10. Coronary artery disease secondary prevention program for members with a history of heart disease. This is a program that helps you reduce your heart disease risk factors through lifestyle changes and group support. Members completing the program are eligible for a $100 reimbursement of the copayment amount. Contact Customer Service for more information.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. More than one routine eye examination in each 24-month period

2. Fittings for contact lenses
3. Eyeglasses or contact lenses
4. Vision therapy or services (also referred to as orthoptics)
5. Services required by a third party or court order. Examples are employment, school, sports, premarital and/or summer camp examinations or tests, and any immunizations required by an employer that are related to your job and/or work conditions.

reconstructive and restorative surgery

The plan covers reconstructive and restorative surgical services for certain conditions.

Reconstructive surgery is covered to **improve or restore bodily function or to correct a functional physical impairment** resulting from an accidental injury, a disease, a congenital anomaly, or a previous noncosmetic surgical procedure. Restorative surgery is covered for **repair of physical appearance** damaged by accidental injury or disease.

Reconstructive and restorative surgery are covered in full subject to the normal inpatient and outpatient copayments and exclusions. An example of a covered procedure is breast reconstruction following mastectomy. Removal of breast implants is covered when (1) there is a complication related to an implant placed for reconstructive purposes or (2) there is documented evidence of autoimmune disease.

You may self-refer to a Fallon Clinic specialist if you have a Fallon Clinic PCP. Services with a non-Fallon Clinic specialist require referral and authorization. Your surgeon must obtain preauthorization from FCHP for all procedures. See **obtaining specialty care and services** for more information on referrals and authorization.

Surgery for cosmetic reasons is not covered. Examples include facelifts and the removal of nonmalignant skin lesions and skin tags.

service

1. Reconstructive surgery to repair a condition resulting from injury, birth defect or noncosmetic surgery
2. Removal of breast implants due to complications of noncosmetic surgery or autoimmune disease
3. Reconstructive surgery for post-mastectomy patients as follows: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prosthesis and any physical complications resulting from the mastectomy, including lymphedema

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Services for cosmetic reasons
2. Services for dental procedures, unless otherwise stated as covered in this *Member Handbook/Evidence of Coverage*
3. Treatment for complications resulting from noncovered cosmetic procedures
4. Custom breast prosthesis

rehabilitation services

The plan covers outpatient rehabilitation services as indicated below. Short-term rehabilitation services such as physical, respiratory and occupational therapy, are limited to a 90-day period per acute episode, beginning with the first office visit. Medical necessity determines the actual number of visits covered.

Services require referral and authorization. (See **obtaining specialty care and services** for more information on referrals and authorization.)

service

1. Physical therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit. Visits after 90 days require prior authorization.
2. Occupational therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit.
3. Respiratory therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit.
4. Treatment for acute episodes of an illness related to a chronic condition when the benefit limit has not been exceeded

5. Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided an FCHP Select Care provider who is a speech-language pathologist or audiologist and at an FCHP Select Care provider facility or FCHP Select Care provider's office
6. Cardiac rehabilitation services to treat cardiovascular disease, in accordance with state law and Department of Public Health regulations
7. Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the Department of Public Health, for children from birth to their third birthday. Benefits are limited to a maximum of $5,200 per calendar year per child and an aggregate benefit of $15,600 over the term of the child's plan membership.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Long-term rehabilitation services
2. Maintenance treatment or services
3. Services for non-acute chronic conditions. Chronic conditions are those that exist for an extended time or continue past the expected recovery time for acute or short-term conditions. For example, the plan defines chronic pain as continuing for more than three months after the injury or illness causing the original pain.
4. Services that are not determined to be medically necessary. This applies to physical therapy, respiratory therapy, speech therapy, occupational therapy and

chiropractic care, even if the plan limits have not yet been reached.

5. Massage therapy, including myotherapy, unless provided by an FCHP Select Care physician or physical therapist with one-to-one patient contact
6. Acupuncture
7. Early intervention services for patients over age 3

skilled nursing facility

The plan covers inpatient services in a plan skilled nursing facility for up to 100 days in each calendar year, provided criteria are met.

You may be admitted to a skilled nursing facility if, based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical or nursing care but do not require the specialized care of an acute care hospital.

Services require referral and authorization. (See **obtaining specialty care and services** for more information on referral and authorization.) The level of services, number of covered days that you are admitted and where you are admitted will be based upon the medical necessity of your condition as determined by your plan physician and the plan.

service (see **inpatient services** for more details)

1. Room and board in a semiprivate room (or private room if medically necessary), for up to 100 days in each calendar year, provided criteria are met
2. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment.
3. Physician services

related exclusions (please see **inpatient services** and **general exclusions and limitations** for more details.)

1. Services beyond 100 days in each calendar year
2. Services that are not determined to be medically necessary, even if the plan limit of 100 days per calendar year has not yet been reached

special formulas

The plan covers the special medical formulas and food products listed below. Except for these items, the plan does not cover any nutritional formulas, supplements or food products.

Covered formula and food items require referral and authorization. (See **obtaining specialty care and services** for more information on referrals and authorization.)

service

1. Special medical formulas to treat certain metabolic disorders as required by state law. Metabolic disorders covered under state law include: phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, methylmalonic acidemia in a dependent child, including when medically necessary to protect unborn fetuses of pregnant women with phenylketonuria.
2. Enteral formulas, upon a physician's written order, for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids
3. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. Coverage is provided for up to $2,500 per member, in each calendar year. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Nutritional supplements, medical foods and formulas unless described above as covered
2. Dietary supplements, specialized infant formulas (such as Nutramigen, Elecare and Neocate), vitamins and/or minerals taken orally to replace intolerable foods, supplement a deficient diet, or provide alternative nutrition for conditions such as hypoglycemia, allergies, obesity and gastrointestinal disorders. These products are not covered even if they are required to maintain weight or strength.

substance abuse services

The plan covers diagnosis and treatment of substance abuse conditions on an outpatient or inpatient basis. A substance abuse condition is defined as a condition as described in the most recent edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association and that is determined as such by a plan provider and the plan. The level of care needed and the program used is authorized by a plan provider. Treatment may be provided by a certified alcohol and drug abuse counselor or other provider as authorized by the plan.

For substance abuse emergencies, follow the same procedures as for any other medical emergency. (See **emergency and urgent care**.)

inpatient services

The plan covers substance abuse services in an inpatient or alternative (diversionary) setting as follows, when authorized by the plan. To access services, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

service

1. Detoxification services for as many days as are required, based on medical necessity
2. Rehabilitation services for alcoholism for up to a maximum of 30 days in each calendar year. (This limit does not apply when treatment is also for a mental disorder.)
3. Rehabilitation services in a day-treatment setting
4. Room and board in a semiprivate room (or private room if medically necessary)

5. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, group and family therapies and diagnostic/laboratory services.
6. Physician services such as medical and rehabilitation services for the treatment of alcohol or drug abuse

intermediate services

Members may receive substance abuse services in an alternative (diversionary) setting in lieu of inpatient hospitalization. This may include, but is not limited to, level III (medically monitored 24-hour residential) community-based detoxification, acute residential treatment, partial hospitalization, day or evening treatment programs and state licensed crisis stabilization services.

service

1. Diversionary services such as crisis intervention, day treatment/evening treatment, or acute residential treatment, as appropriate. Any of these services require authorization from the plan.

outpatient services

Members may self-refer for outpatient substance abuse services. For assistance in finding a contracted provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). The plan covers medically necessary substance abuse services from a plan provider, in an outpatient setting, as follows:

service

1. Outpatient office visits to treat the abuse of, or addiction to, alcohol and drugs. The actual number of visits is determined by medical necessity, and may include individual, group and family therapies.

related exclusions (please see **general exclusions and limitations** for additional limitations)

1. Treatment for personal growth, or other treatment that is not medically necessary, or not in keeping with national standards of practice
2. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling, and training or educational therapy for learning disabilities
3. Alternative therapies such as biofeedback and neurofeedback, and telephone, herbal, art, massage (when not provided by a physician or physical therapist) or music therapy
4. Psychological testing or neuropsychological assessments, unless determined to be medically necessary
5. Services in a residential halfway house
6. Inpatient cocaine detoxification or rapid detoxification for opiate dependency
7. Maintenance therapy utilizing methadone or any chemical intervention agent. This includes medication utilized for maintenance therapy as well as treatment such as counseling for a maintenance program.
8. Elective long-term psychotherapy
9. Mediation or intervention services
10. Faith-based counseling (e.g., Christian counseling)

other plan benefits and features

out-of-area student coverage

Students attending school outside the FCHP Select Care service area may not have easy access to the plan provider network. They are covered for a limited number of services while out-of-area, if authorized in advance by the plan. You must work with your PCP to get plan authorization. These services include:

- Nonroutine medical office visits
- Diagnostic lab and X-ray connected with a nonroutine office visit
- Nonelective inpatient services
- Outpatient services to treat the abuse of or addiction to alcohol or drugs, up to 20 office visits in each calendar year while out of the FCHP Select Care service area
- Outpatient services to diagnose and/or treat mental conditions
- Short-term rehabilitation services, including physical, respiratory, occupational and speech therapy. Coverage for physical and occupational therapy is provided for as many visits as are medically necessary per acute episode, within a 90-day period beginning with the first office visit (combined with any in-area visits). Coverage for speech therapy is provided for as many visits as are medically necessary.

Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. To be covered, all other plan services must be obtained when they return to the FCHP Select Care service area.

Services that are not covered for students while out of the FCHP Select Care service area include:

- Routine physical, gynecological exams, vision screening and hearing screening
- Routine preventive care
- Nonemergency prescription medication. Students may use the prescription medication mail-order program to fill medication refills. (See **prescription medication.**)
- Second opinion
- Dental or oral surgery care, except for the emergency care described on page 147.
- Chiropractic care services
- Home health care
- Outpatient surgical procedures that could be delayed until return to the plan service area
- Maternity care or delivery
- Durable medical equipment (e.g., wheelchairs), including maintenance or replacement

every day health

In addition to providing health care coverage for our members, FCHP offers a variety of resources and wellness features for members who want to take an active role in their health care.

- *Disease care services* support members who have chronic conditions like asthma, congestive heart failure, coronary artery disease and diabetes.
- Eyewear discounts from contracted vendors
- *It Fits!* reimburses eligible FCHP members for participating in a variety of healthy activities: membership at local fitness centers, aerobics, Pilates and yoga classes when taught by a certified instructor, Weight Watchers® programs, and local town and school sports programs for all ages when

they include an aerobic and instructional component. (Note: This program is not available to Direct Enrollment or Bill-at-Home members.)
- *Naturally Well* program offers discounts on acupuncture, massage therapy and chiropractic care.
- Nurse care specialists support members in need of more complex care by serving as their personal health advisor.
- *Oh Baby!* gives participants prenatal vitamins, a child care book, a convertible car seat and more!
- *Tobacco Treatment Program* helps members develop a stop-smoking plan and gives them the tools they need to succeed.

Call Customer Service at 1-866-344-4GIC (TDD/TTY: 1-877-608-7677), or visit the FCHP Web site at www.fchp.org, for more information on these and other programs that are part of *Every Day Health.*

general exclusions and limitations

You are not covered for the following services. These are in addition to the individual exclusions listed in the **description of benefits** section of this handbook; however, this is not an exhaustive list. If you have any questions about your benefits, please contact Customer Service at 1-866-344-4GIC (TDD/TTY: 1-877-608-7677).

1. Services or supplies that are not described as covered in this *Member Handbook/Evidence of Coverage*
2. Any service or supply related to a non-covered service or condition.
3. Acne-related services, including the removal of acne cysts, cosmetic surgery or dermabrasion. (Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.)
4. ALCAT test for food sensitivity
5. All medical, hospital, or other health care services or supplies provided by an non-plan provider, unless approved by a plan provider *and* FCHP in accordance with FCHP policies and rules. FCHP will cover services or supplies rendered by non-plan providers in cases of an emergency medical condition. See **emergency and urgent care.**
6. Alternative therapies such as acupuncture, biofeedback, neurofeedback, aquatic (when not provided by an FCHP Select Care provider as apart of your covered physical therapy benefit), art, herbal, massage (when not provided by an FCHP

Select Care physician or physical therapist as part of your covered physical therapy benefit), music or telephone therapy

7. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling and training, or educational therapy for learning disabilities

8. Any experimental procedure or service that is not generally accepted medical practice. (This does not include the off-label uses of covered prescription drugs used in the treatment of HIV/AIDS or cancer, nor to bone marrow transplants for breast cancer as required by state law.)

9. Any services furnished by any provider not having a license or approval, under applicable state law, to furnish that type of service

10. Any services provided by the Veterans Administration for service-connected disabilities to which members are legally entitled and for which facilities are reasonably available

11. Any services that are the legal liability of workers' compensation insurance or other third party insurer; any illness or injury that we determine arose out of or in the course of your employment

12. Arch supports, foot orthotic devices, and corrective shoes, except as required by law

13. Auditory integration therapy, such as Berard auditory integration therapy

14. Autologous blood donation or storage for use during surgery or other medical procedures

15. Care from a non-plan or out-of-area provider once you are medically able to return to the service area.
16. Care or treatments provided by family members, unless they are licensed health care providers who would have otherwise been gainfully employed performing these services
17. Care that we determine is custodial. Custodial care is defined as a level of care which: (a) is chiefly designed to assist a person with the activities of daily life; and (b) cannot reasonably be expected to greatly improve a medical condition.
18. Charges after the date on which your membership ends
19. Charges that you incur for services not determined to be medically necessary by a plan physician and the plan, such as personal comfort items, or when you choose to stay beyond the hospital discharge hour for your own convenience
20. Clinical or laboratory research
21. Contact lenses are covered only for: cataract after extraction; keratoconus; aphakia; or following a cornea transplant, for up to one year, if medically necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered. Multifocal and presbyopia-correcting lenses are not covered.
22. Continuous glucose monitoring systems
23. Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances
24. Dental treatments and appliances for the treatment of temporomandibular joint (TMJ) disorder or other

conditions. Dental treatment of TMJ is defined as conservative, nonsurgical intervention. This may include, but is not limited to: therapeutic splints, oral appliances and corrective dental treatments (for example, crowns, bridges, braces and/or prosthetic appliances).

25. Dermatoscopy for detection of melanoma
26. Diagnostic tests analyzed in functional medicine laboratories such as Genova Diagnostics
27. Dietary supplements, specialized infant formulas (such as Nutramigen, Elecare and Neocate); vitamins and/or minerals taken orally to replace intolerable foods, supplement a deficient diet, or provide alternative nutrition for conditions such as hypoglycemia, allergies, obesity and gastrointestinal disorders. These products are not covered even if they are required to maintain weight or strength.
28. Early intervention services for patients over age 3
29. Educational services or testing, except services covered under the benefit for early intervention services described in **rehabilitation services**
30. Elective long-term psychotherapy
31. Elective treatment or surgery not required by your medical condition, according to the judgment of the plan
32. Exams or treatment required by a third party unless medically necessary as determined by a plan physician and the plan. Examples are employment or school physicals, premarital medical tests, court-ordered treatment or immunizations required due to your job or work conditions.

33. Experimental implants are not covered. Nonexperimental implants are covered only when medically necessary due to a functional defect of a bodily organ and when the implant will serve to restore full normal function. (Note: This refers to implants. Coverage and exclusions for transplants are described in **organ transplants.**)
34. Extracorporeal Shock Wave Therapy (ESWT) for chronic plantar fasciitis
35. Eyeglasses
36. Fittings for contact lenses
37. Gender reassignment operations and treatments
38. Holistic treatments
39. Housekeeping services and/or homemaking services, including meals
40. Inpatient dental care (except for inpatient hospital services at a plan hospital required when you have a serious nondental medical condition that requires you to be an inpatient when you receive dental services)
41. Investigational, experimental or unproven transplant procedures, including but not limited to:
    - The transplant of partial pancreatic tissue or islet cells
    - A pancreatic transplant that does not follow a kidney transplant or that is not part of a combined pancreas-kidney transplant
42. Laser vision correction surgery
43. Long-term rehabilitation services
44. Maintenance treatment or services

45. Mediation or intervention services
46. Medical care that FCHP determines is experimental, investigational, or not generally accepted in the medical community. Experimental means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by, among other sources, formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing or treatment.
47. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional
48. Nonemergency care provided in an emergency room
49. Nutritional supplements or formulas for adults or children, unless they are described in this *Member Handbook/Evidence of Coverage* as covered
50. Orthodontics
51. Out-of-area care or services that could have been anticipated before leaving the FCHP Select Care service area
52. Over-the-counter birth control preparations or devices

53. Oxygen and related equipment, when received from a non-plan provider. This includes oxygen and related equipment that you are supplied with while you are out of the FCHP Select Care service area.
54. Procedures or services related to dental care, except as shown as covered benefits in the **oral surgery** section of this *Member Handbook/Evidence of Coverage*
55. Provider charges for shipping or copying medical records, or for failing to keep an appointment
56. Psychological testing or neuropsychological assessments unless determined to be medically necessary
57. Reduction mammoplasty for male gynecomastia
58. Removal of nonimpacted wisdom teeth
59. Replacement of lost or stolen Weight Watchers® coupons
60. Rest care or long-term care
61. Routine circumcision performed after an infant's discharge from a maternity hospital admission (unless determined to be medically necessary prior to discharge)
62. Routine foot care. This includes, but is not limited to:
    - Cutting or removal of corns, calluses and plantar keratoses
    - Trimming, cutting and clipping of nails
    - Treatment of weak, strained, flat, unstable or unbalanced feet
    - Other hygienic and preventive maintenance care considered self-care (i.e., cleaning and

soaking the feet, and the use of skin creams to maintain skin tone)
- Any service performed in the absence of localized illness, injury or symptoms involving the foot

63. Routine maternity care when you are traveling outside the plan service area. This includes prenatal, delivery and admission, and postpartum care.

64. Sclerotherapy, joint and ligamentous injections (prolotherapy) for non-symptomatic varicose veins

65. Sensory integration therapy

66. Services and supplies received for reasons of preference or convenience, including services provided by a non-plan provider due to personal preference

67. Services and treatment not in keeping with national standards of practice, as determined by FCHP, including, but not limited to: nutritional-based therapies, non-abstinence-based substance abuse care, crystal healing therapy, Rolfing®, regressive therapy, EST, and herbal therapy.

68. Services authorized to be provided under MGL Chapter 71B in Massachusetts (referred to as "Chapter 766"). These services include, for example:
    - Adaptive physical education
    - Physical and occupational therapy
    - Psychological counseling
    - Speech and language therapy
    - Transportation

    Members who believe that their child may be handicapped (physical disability, mental retardation,

learning problem, or behavioral problem) should seek a Chapter 766 evaluation. Members must make appropriate and reasonable efforts to obtain benefits available under state law.

69. Services covered under the plan that are performed by a member of your family or household, unless that person is a licensed health care provider who would otherwise have been gainfully employed performing these services
70. Services for an organ donor if the recipient is not a member of the plan
71. Services for cosmetic reasons
72. Services for nonacute (chronic) conditions. Chronic conditions are those that exist for an extended time or continue past the expected recovery time for acute or short-term conditions. For example, the plan defines chronic pain as continuing for more than three months after the injury of illness causing the original pain.
73. Services for the organ donor that are covered by another insurer
74. Services furnished to someone other than the member
75. Services in a residential halfway house
76. Services or supplies associated with care for military service connected disabilities for which you are legally entitled to services and for which facilities are reasonably available, or care for conditions that state and local law require be treated at a public facility
77. Services or supplies related to a transsexual operation/gender reassignment

78. Services or supplies that are furnished or paid for, or with respect to which payments are actually provided, under any law of a government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government

79. Services or supplies that are not described as covered in this *Member Handbook/Evidence of Coverage*

80. Services or supplies that are not medically necessary for the prevention, detection or treatment of an illness, injury or disease as determined by a plan physician and the plan. Some examples include (but are not limited to): autopsies, routine circumcision performed after an infant's discharge from a maternity admission, ear plugs to prevent fluid from entering the ear canal during water activities, and nutritional supplements or formulas for adults or children unless described under **special formulas** as covered. Services or supplies that do not meet the plan's medical criteria are not considered to be medically necessary.

81. Services or supplies that are not provided by or authorized by a plan provider, plan dentist or the plan, except in the emergency situations described in **emergency and urgent care**

82. Services or supplies, other than those referred to in item 76 above, that are paid for, or with respect to which benefits are actually provided, under any law of a government (national or otherwise) except where such payments are made or such benefits are provided under a plan specifically established by a

government for its own civilian employees and their dependents

83. Services received after the date that coverage ends

84. Services that a third party or court order requires. Examples are employment, school, sports, premarital and/or summer camp examinations or tests; court-ordered treatment or evaluations; competency, adoption or child custody/visitation evaluations; and any immunizations required by an employer, related to your job and/or work conditions.

85. Services that are considered experimental or which have not been approved by a plan medical director

86. Services that are covered by another insurer

87. Services that have not been authorized by the plan, including nonemergency services received out of the FCHP Select Care service area, or services beyond the plan benefit limits

88. Services to reverse a voluntary sterilization

89. Special duty or private duty nursing and attendant services

90. Specialty clothing appropriate to specific medical conditions

91. Supplies that may be purchased without a physician's written order

92. Tinnitus masker

93. Total body photography

94. Travel, transportation and lodging expenses for a member and/or a member's family as a course of treatment or to receive consultation or treatment
95. Treatment by telephone
96. Transportation between hospitals when your medical condition does not warrant that you be transported to another facility
97. Treatment for complications resulting from noncovered cosmetic procedures
98. Treatment for personal growth, or other treatment that is not medically necessary, or not in keeping with national standards of practice
99. Unauthorized in-area urgent care visits
100. Unskilled nursing home care
101. Vision therapy or services (also referred to as orthoptics)
102. Visits to additional providers beyond a second opinion, or a second opinion with a non-plan provider
103. Vitamins and minerals, whether or not a prescription is required
104. Vocational rehabilitation, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation
105. Weight control programs
106. Any service or supply related to a non-covered service or condition
107. White noise machines

108. Auditory integration therapy, such as Berard auditory integration therapy
109. Total body photography
110. Home video EEG monitoring

cosmetic services

FCHP does not cover cosmetic services, follow-up treatment for cosmetic services, or treatment for complications resulting from cosmetic procedures. The primary purpose of cosmetic or beautifying surgeries, procedures, drugs, services or appliances is to improve, alter or enhance appearance or self-image. They are not necessary to maintain or restore an essential bodily function, or they are performed for psychological or emotional reasons.

Below are some examples of procedures that are considered cosmetic in nature and are not covered:

- Botox injections for cosmetic purposes
- Breast implants
- Chemical exfoliation for acne
- Chemical peel
- Chin implant (unless for the correction of a deformity that is secondary to disease, injury or congenital defect)
- Collagen implant (e.g., Zyderm)
- Correction of diastasis recti abdominis
- Dermabrasion for removal of acne scars
- Earlobe repair to close a stretched or torn pierced ear hole
- Electrolysis for hirsutism
- Excision of excessive skin on thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, or other areas, unless there is documentation of a permanent weight loss of 50 or more pounds, and documentation of recurrent skin rashes or other functional impairment that does not respond to more conservative treatment
- Excision or repair of keloid

- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Rhytidectomy (face lift)
- Salabrasion
- Scar revision
- Suction-assisted lipectomy

This list is not exhaustive; any procedure considered cosmetic in nature will be excluded, unless to repair or restore bodily function as a result of illness, injury, birth defect or covered surgical procedure.

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